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REAUTHORIZATION OF THE NATIONAL INSTITUTE OF ALCOHOL ABUSE AND ALCOHOLISM AND THE NATIONAL INSTITUTE ON DRUG ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON
CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

ON

REVIEWING LEGISLATIVE INITIATIVES TO REAUTHORIZE FEDERAL RESEARCH PROGRAMS AIMED AT PREVENTING SUBSTANCE ABUSE

FEBRUARY 20, 1986

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REAUTHORIZATION OF THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM AND THE NATIONAL INSTITUTE ON DRUG ABUSE

THURSDAY, FEBRUARY 20, 1986

U.S. Senate,
Subcommittee on Children,
Family, Drugs and Alcoholism,
Committee on Labor and Human Resources,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:07 a.m., in room SD-430, Dirksen Senate Office Building, Senator Paula Hawkins (chairman of the subcommittee) presiding.

Present: Senators Hawkins, Hatch and Dodd.

OPENING STATEMENT OF SENATOR HAWKINS

Senator Hawkins. Good morning.

As Chairman of the Subcommittee on Children, Family, Drugs and Alcoholism, I am pleased to welcome you to this morning's hearing on the reauthorization of the National Institute of Drug Abuse, NIDA, and the National Institute of Alcohol Abuse and Alcoholism, more commonly known as NIAAA.

The character of substance abuse in our society deeply concerns me, and I am committed to the essential vision of these institutes.

The economic, social and human costs of alcohol abuse and alcoholism are devastating to our society, and we have all seen estimates. The cost of alcohol abuse is $116.7 billion annually, and the cost of drug abuse is $59.7 billion a year. Lost employment and reduced productivity account for the majority of this cost to our society.

Our society also pays a price in the areas of health care, crime, motor vehicle accidents, and excess morbidity and mortality.

But concerns over substance abuse cannot be easily reduced to dollars and cents. Consider the impact of an addicted individual serving as the head of a household. Think of the promising teenager giving up sense of self to substance abuse. Think in human terms—and the staggering effects of drug and alcohol abuse upon the emotional and physical health of our society as a whole becomes clear and frightening.

I recently received an impassioned plea from a 23-year-old convict who had been imprisoned for possessing a small amount of cocaine. He said, "I thought I could make a quick buck, but I have ruined my life, the life of my family, all of our futures." He urged me in his letter to, "Warn others not to make the same mistake." I will do all that I can to honor that request.

The illegal drug corporations fight for the control of our society through the most basic principle of economics—supply and demand. To be truly effective, the war on drugs must take the same approach.

I have long fought for stiff penalties for drug pushers who would profit from destroying young minds and bodies. I have pushed for reduced aid to countries that permit the influx of drugs into America. That is the supply side.

Today, we discuss the demand side: Fighting drug abuse here at home. I have encouraged quality drug abuse education for our children. As a mother, as a grandmother, and as a Senator, I am committed to this fight as long as I have breath within me.

This morning we will hear from a distinguished group of experts whose testimony will provide essential input for the reauthorizing legislation for these institutes. More specifically, today's panelists will reveal the progress of research efforts seeking to identify the relationship between substance abuse and fetal deformities, genetic traits, trauma recovery and academic performance.

We will also learn the latest that medical research has learned about the connection between alcohol, illegal drugs, and the AIDS epidemic.

We will also discuss initiatives the institutes have undertaken as a result of the previous reauthorization authority. In the past this subcommittee has required among other things the development of a private media campaign to discourage substance abuse, a national plan to combat alcoholism and an increased emphasis in research on women and substance abuse.

I am eager to hear from the experts we have assembled here today about their progress in the war against the substance abuse epidemic that threatens our very existence as a society.

Before I welcome our first panel, I would like to recognize our Chairman, Senator Hatch.

OPENING STATEMENT OF SENATOR HATCH

Senator **Hatch**. Well, thank you, Madame Chairman.

I am grateful to be with you today, and I appreciate your leadership in the area of alcohol and drug abuse research.

In a suburban city in the United States last winter, a teenager passed out during a drinking bout, and he lay for 6 hours in the snow before he was found and taken to a hospital. The police said, "It is a miracle that the boy is still alive."

The youngster spent several days in the hospital, where he was listed in fair condition and treated for severe hypothermia and frostbite.

What happened is the boy and three of his school friends, one of whom had stolen a bottle of liquor from his parents' home, had gathered in a field behind a store and proceeded to get drunk.

Now, this story is unique only in the sense that the young man was found and therefore did not die as a result of the binge.

The sad truth is that situations like this occur throughout America. It happens in rural communities, and it happens in cities and suburbs. Personal tragedies continue to plague us because of the misuse and abuse of alcohol and drugs.

Alcohol and drug abuse is a problem of epidemic proportions in the United States, affecting people in every age group and income bracket. I might add that its consequences are devastating to abusers, victims, families, and communities.

I am pleased to join with Senator Hawkins, chairman of the Subcommittee on Children, Family, Drugs and Alcoholism and other subcommittee members, in reviewing legislative initiatives to reauthorize Federal research programs aimed at preventing substance abuse.

The National Institute on Alcoholism and Alcohol Abuse and the National Institute on Drug Abuse are preeminent research institutes.

It is true that from research granted from these programs that we have learned of the adverse impact of cocaine on the body's neurological system. We have learned the addictive effects of marijuana and nicotine, and we have learned the importance of the family in the treatment, identification and prevention of alcoholism.

These are only a few examples of the fine work that has been supported by NIAAA and NIDA. I will continue to be a strong advocate for Federal support of research into the causes, cures and preventions of alcoholism, alcohol abuse and drug abuse.

We must find a way to cure the alcohol or drug-dependent citizen and reestablish them within the mainstream of society.

Further, the costs associated with substance abuse are staggering. Alcohol abuse is estimated to top $110 billion, while drug abuse costs are estimated at $60 billion. The benefits of research findings can only help us in reversing these costly social programs. Money spent on research is, in my opinion, money well-invested.

Today I also want to explore the research findings that have resulted from our increased emphasis on alerting women to the dangers of substance abuse. It is my hope that all witnesses will address that subject in their testimony.

In conclusion, I want to thank Senator Hawkins for her commitment to reverse the tragic impact of substance abuse among all of our Nation's citizens. This is a war that we all must take part in if we desire to win it. And I think, Senator Hawkins, you have done as much as anyone in the history of the Senate to try and address these concerns, and I personally am very appreciative as chairman of this committee to follow your leadership in this area.

So I appreciate your having the hearing.

Senator **Hawkins**. Thank you, Mr. Chairman.

At this point I will include statements in the record by Senators Dodd, Grassly, and Kerry.

[The statements referred to follow:]

STATEMENT OF SENATOR CHRISTOPHER J. DODD

Senator **Dodd**. Madam Chairman, I am pleased the subcommittee this morning is considering the reauthorization of two very important institutes: The National Instititue of Alcohol Abuse and Alcoholism and the National Institute of Drug Abuse. As ranking minority member of this subcommittee and as founder and co-chair of the Senate Children's Caucus, I will be particularly interested to hear of the activities of these two institutes as they relate to the 64 million Americans who are children.

Last year, the Connecticut Association for Human Services and the Junior League of Hartford released a book entitled "Growing Up At Risk in Connecticut." One of the risk factors highlighted was substance abuse. In 1981, for example, one out of every five people arrested for narcotics related offenses in Connecticut was a child. Last year, close to one of every four junior and senior high school students in my State admitted to drinking alcohol at least once a week. And today, drug and alcohol-related motor vehicle accidents remain the chief cause of death among Connecticut teenagers.

Last year, I learned first hand about the pressing problem of drug abuse by young people in my State of Connecticut. I met with a group of undercover law enforcement officers who took me to a city — a typical Connecticut town — where I observed cocaine "car hops" providing curb service to buyers of illegal drugs. I talked to a 14-year-old boy in Norwalk who told me he started drinking at age eight, and a 14-year-old girl who had abused alcohol, marijuana, uppers, downers, cocaine, angel dust, and LSD before undergoing treatment.

Unfortunately, such histories of childhood drug abuse are not isolated. National surveys indicate that one child of every three in this country has been intoxicated by alcohol or other drugs reaching age 11.

There is hope in the midst of these grim statistics, hope presented by a wide range of prevention and early intervention programs. Several nationwide studies indicate a drop in youth drug abuse over the past decade due to prevention efforts.

In my State of Connecticut I have visited prevention programs. I sat in a kindergarten classroom in West Hartford, watching a teacher use puppets to teach preschoolers about the dangers of alcohol and drug abuse. I have spoken with high school students in Monroe who counsel younger students about drug and alcohol abuse, and to teenagers in Darien who perform skits to teach their peers about the same problem.

Investing in prevention programs such as those I have visited in my State of Connecticut is one of the most cost-effective ways to curb youth substance abuse. I hope we will be able to target further resources on prevention efforts in the future.

I look forward to hearing the testimony of our distinguished witnesses this morning. I am especially pleased that Dr. Thomas Babor from my State of Connecticut is here to describe the research he is overseeing on the children of alcoholics and the link between domestic violence and alcohol abuse.

STATEMENT OF SENATOR CHARLES E. GRASSLEY

Senator **Grassley**. Madam Chairman, thank you for calling this hearing on the reauthorization of the National Institute of Alcohol Abuse and the National Institute of Drug Abuse.

Many here today have always known that alcohol and drug abuse is a major health and social problems. Only a few years ago excessive use of intoxicants received only a polite rebuke—in those days drinking was viewed as part of the sophisticated and successful life. Fortunately, these attitudes have been supplanted by both an attitude of disapproval that discourages young people from getting started, and by a commitment to compassion and understanding for those who need help to stop.

The carnage on our highways, health risks during pregnancy, broken family relationships, lost careers, are the tragic and cruel lessons that have confirmed the steadfastness of those who will testify here today. Thankfully, rescue efforts through education programs and counseling referral programs have heightened the awareness that substance abuse places the user and our society at great risk.

I hope to hear today, of the administration's efforts to develop a national strategy to effectively combat substance abuse.

Especially encouraging are the efforts of those who play a Federal role to work with private sector sponsors such as insurance companies and corporations. Those in the workplace have an important stake in what is being done. More than 75 percent of chemical abusers are employed. In 1983, the reduced productivity of employees with alcohol and drug problems was estimated at $65 billion and $35 billion respectively. Additionally, estimated expenditures for health services to chemical abuse victims included $15 billion for alcohol abuse and $2 billion for drug abuse.

By communicating the latest and most effective prevention information and by providing technical assistance, a great service is provided to employers who otherwise might not have the resources to respond.

I am also very concerned by what is happening in my own state of Iowa. We are facing a severe depressed farm/agribusiness economy. As a result, there has been a dramatic increase in suicides, teen runaways has increased approximately 15 percent, child abuse has increased 25 percent and of course, there has been a dramatic increase in substance abuse. I am most anxious to hear what the administration is doing and plans to do in our situation in Iowa.

Finally, I would encourage those who are working with youth to expand their efforts to teach our young people to say "no". In the 1984 Iowa criminal and juvenille justice plan submitted to the Governor, it was noted that "Alcohol and drug abuse is the No. 1 problem in the criminal justice system. These are real problems that need to be dealt with.

STATEMENT BY SENATOR JOHN KERRY

FEBRUARY 20, 1986

REAUTHORIZATION HEARING ON THE
NATIONAL INSTITUTE OF DRUG ABUSE AND
THE NATIONAL INSTITUTE OF ALCOHOL ABUSE AND
ALCOHOLISM

MADAM CHAIRMAN -- I am pleased to be here today for the reauthorization hearing of the National Institute of Drug Abuse (NIDA) and the National Institute of Alcohol Abuse and Alcoholism (NIAAA). These Institutes address issues of overriding importance and issues that derserve real commitment from our Nation's policymakers. Recent studies continue to reveal the tragic magnitude of alcohol and drug related problems for individuals and their families, which reinforces the importance of the mission we have given to the National Institutes of Drug Abuse and Alcohol Abuse.

The consequences of alcohol and drug abuse have only slowly been recognized, but a close study of the effects of chemical dependency indicate that few aspects of daily life are exempt. Health care data has tended to provide some of the most complete correlations between the use and abuse of alcohol and drugs. Alcohol abuse alone is responsible for up to 15% of our nation's health costs, it is the 8th leading cause of death in the US from liver cirrhosis, and fetal alcohol syndrome is the 3rd leading cause of birth defects with accompanying mental retardation in the US. In this final instance, it ranks only behind Down's Syndrome and Spina Bifida.

Citizen groups have had tremendous impact in the public's knowledge of drunk driving which is the contributing factor in 50% of all traffic deaths. Not so widely known, though, is the law enforcement data which shows alcohol and drug use as contributing factors in most crimes and most especially in homicides and rapes.

Employment continues to figure largely when we study the economic costs of alcohol and drug abuse. A 1975 NIAAA study cited the largest economic cost of alcohol abuse and alcoholism was the $19.6 billion accounted for by lost production of goods and services, and more directly the premature mortality, reduced productivity, lost work time, and the lost employment.

Finally, and most importantly, the consequences of alcohol and drug abuse impact on the family. On an average, one out of three Americans reports that drinking has been a cause of trouble in his or her own family and the most readily apparent victims are the children. Information provided by the Children of Alcoholics Foundation shows that teenage children of alcoholics are twice as likely to have psychiatric treatment and children of alcoholics are three times more likely to be expelled from school, or drop out early. And preliminary reports show an alarming relationship between parental alcoholism and adolescent suicide.

Many activities to treat and prevent alcohol and drug abuse are developing in private organzations and private industry. For example, the American Bar Association approved a sweeping program last year to combat teen-age alcohol and drug abuse. Many corporations and small businesses are providing counseling for substance abuse, recognizing the economic costs of alcohol and drug abuse. CBS reflects a responsive change on the part of the TV medium by scheduling two serious dramas this winter which deal with chemical dependency.

However, treatment and prevention programs remain the focus of the most innovative approaches to preventing and reducing alcohol and drug abuse. For example, in Hingham, Massachusetts, Project Turnabout, Inc. has recently initiated a new short-term treatment program for both the inpatient and outpatient settings to serve individuals who have not yet lost their jobs or support systems. So often services respond only when individuals have reached the "bottom." This initiative will not only fill the urgent need to supply services to those individuals in the early stages of chemical dependency, but will also generate enough revenue to help their agency cover the cost of providing services to those individuals who are less fortunate and cannot afford to pay for drug treatment.

Another Massachusetts organization called F.I.R.S.T, INC. provides education, prevention, outreach, and treatment in the greater Boston area. A crackdown on drug trafficking in the Boston area has also resulted in a shortage of drugs on the streets which, in turn, has also resulted in a significant increase in the number of substance abusers seeking treatment. Despite very limited resources, F.I.R.S.T. has tried to respond to the increased demand for their services and their efforts have been admirable.

Through the efforts of private groups and federal entities like NIDA and NIAAA there has been some good news in the treatment and reduction of chemical abuse. Research has demonstrated the importance of genetics to alcoholism and public knowledge of Fetal Alcohol Syndrome (FAS) has taught women that FAS is preventable through abstaining from alcohol consumption during pregnancy.

However, as Lloyd Johnston recently said in a November Washington Post article, "we cannot take the improvement of recent years for granted." Lloyd Johnston was one of the authors of a study of high school seniors on teenage drug and alcohol use. This study showed the five year national downswing in teenage use of illegal drugs, as well as alcohol, seems to have leveled off this year. In fact those who have tried cocaine reached a record high number and daily alcohol use has increased to five percent.

The reauthorizations of NIDA and NIAAA are crucial to our research efforts and I look forward to the dialogue during this hearing which will guide us in continued progress that in recent years has been most promising.

Senator **Hawkins**. Our first panel this morning will include Dr. Donald Ian Macdonald, St. Petersburg, FL, who now serves as Acting Assistant Secretary for Health of the Department of Health and Human Services. I understand, Dr. Macdonald, that you have a conflict which will prevent you from remaining. I am extremely pleased that you have joined us here again this morning.

Also on this same panel will be Mr. Loran Archer, who serves as Acting Director of the National Institute on Alcohol Abuse and Alcoholism, and Dr. Jerome Jaffe, Acting Director of the National Institute on Drug Abuse.

Our second panel will include two well-renowned researchers who have pioneered therapeutic treatment for drug and alcohol abusers.

Dr. Macdonald.

STATEMENT OF DR. DONALD IAN MACDONALD, ACTING ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROBERT TRACHTENBERG, ACTING ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION; LORAN ARCHER, ACTING DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM, AND DR. JEROME H. JAFFE, ACTING DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. MACDONALD. Madame Chairman and members of the subcommittee, we appear before you this morning to discuss the research programs of the National Institute on Alcohol Abuse and Alcoholism, NIAAA, and the National Institute on Drug Abuse, NIDA, which are parts of the Alcohol, Drug Abuse, and Mental Health Administration, ADAMHA.

With me this morning are the two gentlemen you mentioned in your opening remarks, and Mr. Robert Trachtenberg, who is the Acting Administrator of ADAMHA. I might add that Secretary Bowen has recently named Dr. Charles R. Shuster to be the permanent Director of NIDA, and we hope that he will be onboard March 1.

Before the acting directors tell you in detail of the accomplishments of their Institutes, and their very important forward-looking plans, I would like to express the administration's view on research authorizations.

It is our view that the authorization to perform basic research for these two Institutes should come under the general research authority contained in section 301 of the Public Health Service [PHS] Act. This is the same act which covers the medical and behavioral research authority for programs of our third Institute, the National Institute of Mental Health, NIMH, and for many of the Institutes of the National Institutes of Health, NIH.

To understand why we seek this change from reauthorization of separate alcohol and drug authorities, a brief historical overview seems pertinent. ADAMHA, the parent agency of these two Institutes, was created in 1974 by removing NIMH from the Health Services and Mental Health Administration, and combining it with two newly created Institutes, NIAAA and NIDA, which at one time were parts of NIMH. An Office of the Administrator was formed to coordinate efforts in the areas of services, training and research.

NIAAA was created and funded for many years under the Comprehensive Alcohol Abuse and Alcoholism, Prevention, Treatment and Rehabilitation Act and various extensions which followed. NIDA was created and funded under the Drug Abuse Office and Treatment Act and successor acts.

Our third ADAMHA Institute, NIMH, has a different basis and has always utilized section 301 of the PHS authority for research since its inception in 1947, when it was part of the original NIH. Other legislation, authorizing the Community Mental Health Centers Program, was added later.

Thus, from its inception in 1974 to its major mission change in 1981, the ADAMHA drew its legislative base from three distinctly different sources. It cannot be emphasized too highly that during this earlier period, the major mission of this agency was different than it is now. Its primary mission then was to direct support and nurturing of services delivery in the newly evolved alcohol, drug abuse, and mental health services fields. This mission included allocating formula grants to States and providing project grants to both public and nonprofit private entities delivering alcohol, drug abuse and mental health services.

This support required each State to establish a single State agency to oversee planning and operation of the alcohol and drug abuse delivery systems.

In these early days of the agency, the Congress felt that a statement of support through separate, time-limited authorizations, was necessary to give credibility and special emphasis to these highly stigmatized and underdeveloped fields.

I am certain you remember President Nixon's War on Drugs and the congressional efforts which gave impetus to the creation of NIDA, and the so-called "Hughes Act" out of which NIAAA was formed.

The "new federalism" approach of President Reagan began a pronounced turning point for ADAMHA. With the Omnibus Budget Reconciliation of 1981, the Federal Government turned over to the States the responsibility for treatment and prevention services delivery. This was accomplished by enactment of various health services block grants, including the Alcohol, Drug Abuse and Mental Health Services Block Grant.

Enactment of the Block Grant Program fundamentally changed the mission of ADAMHA by making research its major mission. And most of the provisions of the Drug Abuse Office and Treatment Act and the act that constituted the Alcoholism Institute were subsequently repealed.

All of this is of great relevance to our presentation today. As a result of these changes, the agency undertook a major reduction in force in 1982 and reorganized itself along new functional lines to support increased research into the ADM disorders.

The Congress recognized this, and in 1984 recodified all of ADAMHA's major authorities in a new title V of the PHS Act. Also, administration budget requests for ADM research have been consistently higher over the years following 1981, and I can assure you that the administration intends to continue funding research in alcohol and drug abuse field.

The agency now finds itself in the anomalous position of having one Institute utilizing section 301, which does not require periodic reauthorization, and two smaller Institutes utilizing a different set of authorities which do require periodic reauthorization.

These two Institutes perform research which is as good as any conducted anywhere in the world, with paylines and priority scores which are exceptional. Because of the exceptional nature and the enduring quality of their research, we believe they should be treated the same as other research institutes in the Public Health Service. When they were created, they were given separate legislative authority to nurture and protect them. Now, that same authority appears to work against them. A clearer statement of their new research mission could be given if they were not required to come before Congress every 2 years to justify their existence as research entities.

As you know, it is the official administration policy that all health research be conducted utilizing the general authority of section 301, since this lends stability to the research enterprise and allows flexibility to pursue new avenues of research such as AIDS, without needing to seek specific new authorization each time a new health priority emerges.

An unfortunate and unintended consequence of continuing a process of periodic reauthorization is that it sends a very destabilizing message to researchers. It seems to imply that these two Institutes lack the long-term stability that their sister institutes enjoy. This could be an unfortunate message to research fields that need to attract, train and retain the best scientific minds possible.

Because of all this, we propose to allow these Institutes to utilize section 301 authorities in lieu of sections 513 and 517. For this to happen, no action is required by this subcommittee. Simply letting sections 513 and 517 lapse will have the effect of allowing us to utilize the 301 authority. No current research activities will be affected in any way by such a change.

We appreciate the continuing support of this subcommittee, and especially you, Madame Chairman, in the areas served by these two Institutes. We do not see this proposed change as a move to lessen your involvement or oversight authority.

We thank you for your interest and would expect to participate in oversight hearings to provide an active accounting of how these Institutes are performing in key research areas. Some things will not change. Our major services effort, the Alcohol and Drug Abuse and Mental Health Services Block Grant would, of course, still remain on a time-limited authorization.

All of the provisions such as knowledge transfer and private sector involvement required in title V would still be available for the subcommittee to review and amend as necessary.

Madame Chairman, the research program of these two Institutes has come of age, and we ask your support in sending this message to the field.

I apologize for my need to speak and run, but I have asked Mr. Trachtenberg and these gentlemen to answer any questions you might have, and I want to thank you again for your continued great interest.

[The prepared statement of Dr. Macdonald follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Office of the Assistant Secreta
for Health
Washington DC 20201

For Release Only Upon Delivery

STATEMENT

BY

DONALD IAN MACDONALD, M.D.
ACTING ASSISTANT SECRETARY FOR HEALTH

ON

ALCOHOL AND DRUG ABUSE RESEARCH AUTHORITIES

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

THURSDAY, FEBRUARY 20, 1986

Madame Chairman and Members of the Subcommittee:

It is a great pleasure to appear before you today to discuss the research programs of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) of the Alcohol, Drug Abuse, and Mental Health Administration. Accompanying me today are Mr. Robert Trachtenberg, Acting Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, Mr. Loran Archer, Acting Director of NIAAA, and Dr. Jerome Jaffe, Acting Director of NIDA. I might add that Secretary Bowen has recently named Dr. Charles R. Schuster to become permanent NIDA Director. Dr. Schuster will be aboard March 1.

Before the Acting Directors tell you in detail of the accomplishments of their Institutes, and their very important forward-looking plans, I would like to express the Administration's views on research authorizations. It is our view that the authorization to perform basic research for these two institutes should come from the general research authority contained in Section 301 of the Public Health Service Act (42 U.S.C. 241) -- the same as medical and behavioral research authority for programs of the National Institute of Mental Health and for many of the Institutes of the National Institutes of Health.

To understand why we seek this change from reauthorization of separate alcohol and drug authorities, a brief historical overview is pertinent. The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), parent agency of these institutes, was created in 1974 by taking the National Institute of Mental

Health from the Health Services and Mental Health Administration, and combining it with two newly created institutes (NIAAA and NIDA) and creating an Office of the Administrator to coordinate efforts in the areas of services, training, and research, (Title II of P.L. 93-282). NIAAA was created and funded for many years under the Comprehensive Alcohol Abuse and Alcoholism, Prevention, Treatment and Rehabilitation Act and various extensions which followed. NIDA was created and funded under the Drug Abuse Office and Treatment Act and successor acts. NIMH, on the other hand, has always utilized the section 301 PHS Act authority for research which it has had since its inception in 1947 as part of the original National Institutes of Health. Other legislation, authorizing the Community Mental Health Centers program, was added later.

Thus, from its inception in 1974, to 1981 the ADAMHA drew its legislative base from three distinctly different legislative sources. It cannot be emphasized too highly that during this period the major mission of the agency was direct support and nurturing of services delivery in the newly evolved alcohol, drug abuse, and mental health services fields. This mission included formula grants to States, and project grants to both public and non-profit private entities delivering alcohol, drug abuse and mental health services. This support required each State to establish a single state agency to oversee planning and operation of the alcohol and drug abuse delivery systems. In these early days of the agency, the Congress felt that a separate statement of support through separate, time- limited authorizations was necessary to give credibility and special emphasis to these highly stigmatized and underdeveloped fields. I am certain you remember President Nixon's War on Drugs and congressional efforts which gave impetus to establish NIDA, and the so-called "Hughes Act" which gave impetus to establish NIAAA from their division status within NIMH.

The New Federalism approach of President Reagan marked a pronounced turning-point for ADAMHA. With the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) the Federal Government turned the responsibility for treatment and prevention services delivery over to the States. This was accomplished via enactment of various health services block grants, including the Alcohol and Drug Abuse and Mental Health Services Block Grant (Part B, Title XIX, PHS Act 42 USC 300x). Most of the provisions of the Drug Abuse Office and Treatment Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act were no longer relevant and were repealed. Enactment of the block grant program fundamentally changed the mission of ADAMHA, making research the major mission while relegating services delivery and support to that necessary only to administer the block grant. Accordingly, the agency undertook a major reduction-in-force in 1982 and re-organized itself along functional lines to support increased research into the ADM disorders. The Congress recognized this, and in 1984 recodified all of ADAMHA's major authorities in a new Title V of the PHS Act. Administration budget requests for ADM research have been consistently higher over the years following 1981. I can assure you that the Administration intends to continue to request funding for alcohol and drug abuse research.

The agency now finds itself in the anomalous position of having one institute utilizing section 301 of the PHS Act, which does not require periodic re-authorization, and two smaller institutes utilizing a different set of authorities which require periodic re-authorization. These two institutes perform research which is as good as any conducted anywhere in the world, with paylines and priority scores which are exceptional. These institutes believe that because of this early history they are now being singled-out in a way that most other research institutes at NIH and ADAMHA are not: i.e. they must periodically come before the Congress to justify their existence as research entities. It is official Administration policy that all health research be conducted utilizing the general authority of section 301, since this lends stability to the research enterprise and allows flexibility to pursue new avenues of research (such as AIDS) without needing to seek a specific new authorization each time a new health priority emerges.

An unfortunate and unintended consequence of continuing a process of periodic reauthorization is that it sends a very de-stabilizing message to researchers, i.e. that these two institutes lack the long-term stability that their sister institutes enjoy. This is a critical message to research fields that need to attract, train, and keep the best scientific minds possible. Accordingly, the Administration proposes to allow these institutes to utilize the section 301 authorities in lieu of sections 513 and 517. Such an action requires no affirmative step on the part of this subcommittee. Simply letting sections 513 and 517 lapse will have the effect of allowing us to utilize section 301. No current research activities will be affected in any way by such a change.

I wish to assure you that oversight hearings would still be available to serve as an active accounting of how these Institutes are performing in key research areas. Our major services effort, the Alcohol and Drug Abuse and Mental Health Services Block Grant, would of course, still remain on a time-limited authorization. All of the provisions such as knowledge transfer and private-sector involvement required in Title V of the Public Health Service Act would still be available for the subcommittee to review and amend as necessary. Only the need to periodically re-authorize the basic research which we are already doing, and will continue to do, would be affected.

Madame Chairman, the research program of these two institutes has come of age, and we ask your support in sending this message to the field.

Thank you. I would be pleased to answer any questions you might have.

Senator **Hawkins**. Thank you, Dr. Macdonald.

Mr. Archer.

Mr. **Archer**. Madame Chairman, my name is Loran Archer, and I am the Acting Director of the National Institute on Alcohol Abuse and Alcoholism. I am accompanied by Dr. Boris Tabakoff, who is the Acting Deputy Director and the Scientific Director of our Intramural Research Laboratories, and who will also be available to answer any of the particular technical aspects about research that you might be interested in.

The revised fiscal year 1986 budget provides funding for NIAAA research activities at a level of $54.4 million, an increase of $5.6 million over fiscal year 1985. Increased funding for alcohol research during the past several years has enabled us to expand our research into the causes of alcoholism, early identification and prevention of alcohol-related problems, and more effective methods for treatment.

Budget priorities in the coming year include increased support for research in genetics, treatment, and prevention.

In my current position as Acting Director, I would like to thank the subcommittee for the interest and support it has shown in the past and hopefully in the future, in reducing the problems of alcohol abuse, and alcoholism.

We particularly appreciate your concern and welcome your assistance as we strive for a better understanding of alcohol abuse, and of alcoholism as a disease which has taken and continues to take a devastating toll on this Nation.

I have submitted to the subcommittee a prepared statement and at this time will highlight the statement, for the purposes of time, and then will make myself available for questions that the subcommittee might have.

I would like to review with you some of our activities and accomplishments and our plans for the future in research, research dissemination, and the broad field of prevention.

Among one of the more significant research developments is the confirmation that the disease of alcoholism often has a genetic base. Further, this genetic predisposition to alcoholism may be accompanied by a characteristic physical and biochemical marker that can be detected in the laboratory.

These findings hold tremendous potential for the future of alcoholism prevention and treatment. They open the prospect for the utilization of genetic markers to identify individuals at risk of alcoholism before the disease is manifested.

I have asked staff to provide you with copies of our most recently publication, which is entitled, "Alcholism: An Inherited Disease". This publication describes some of the significant new knowledge which is coming out of research in the genetics of alcoholism.

As new technologies are developing, a most dramatic research technique having a major significance in the alcoholism field is the new noninvasive technology which is being applied in studies of the biological effects of alcohol.

Among the most powerful techniques which are presently available is the utilization of nuclear magnetic resonance (NMR). The diagnostic and research capabilities of the NMR procedure are enormous. This will assist us to provide much more rapid and extensive information on the mechanisms of the disorders of alcohol cirrhosis and cardiac damage from the excessive use of alcohol, brain damage, the fetal alcohol syndrome, alcohol tolerance, and alcohol dependence.

Partly because of the concern across the Nation regarding the Acquired Immune Deficiency Syndrome (AIDS) research activity on the immunosuppresant aspects of alcohol is increasing.

It has long been known that heavy drinkers are more susceptible to bacterial infection, but little is known about alcohol's effects on resistance to viral infections. For this reason, NIAAA convened a committee of experts to review the current state of knowledge of the effects of alcohol on the immune system and the possible interrelationships between alcohol and AIDS.

In the alcohol areas, the identified topics of particular research which were recommended by this committee included mechanisms underlying the role of alcohol as a cofactor in cell mediated immunity and its potential effects on the acquisition of HTLV-III reactivity and the development of AIDS. This is an exciting, innovative area in which we hope the Institute can be a pioneer.

Alcohol treatment, as a result of major findings from research, has changed considerably in the past decade. These changes include increased availability of third-party payment for treatment, the expansion of treatment services, both inpatient and outpatient, an increase in the number of employee assistance programs providing early identification and early referral for treatment, and the major advent of referral programs for drinking drivers as an early identification of individuals with impairment on the highways into highly effective treatment programs.

Notable advances have been achieved. We are continuing to stimulate new approaches for patient treatment and patient placement.

However, there are still many treatment research questions which need to be studied. For example, the relatively effectiveness of different therapies and modalities; the appropriateness of all levels of care whether it be inpatient, outpatient or other types of residential care; the optimum length of stay, and the ideal mix of treatment. We will be examining all of these questions in our research efforts.

However, from the research that has been carried out in the last decade, one thing is increasingly clear. That is—alcohol treatment is highly effective. Health care utilization and costs decline significantly following treatment for alcoholism

On the average, the alcoholic and the alcoholic family utilizes health care services at a rate twice as high as the general population, imposing a major cost on the total health care system.

However, study after study have documented that with the provision of specialized alcoholism treatment, those costs can be alleviated, and that following treatment, the decreased health costs both for the alcoholic and the alcoholic family will more than offset the costs of the treatment in less than 2 years.

We are presently carrying on a joint demonstration study between NIAAA and the Health Care Financing Administration to measure the feasibility and effectiveness of alternative levels of residential and outpatient care to look at alternative, less costly methods of care.

While the evaluation is still under way, preliminary findings have once again substantiated the finding of reduced utilization of health care following alcoholism treatment; and this in a particularly substantially impaired population, one-half of whom are disabled severely enough to be considered as permanently and totally disabled by the Social Security Administration.

In addition to its extramural research on treatment, the Institute supports intramural clinical research program at the campus of the National Institutes of Health.

In recent years, Congress has directed that special consideration be given to research on alcoholism and alcohol abuse among women. We were pleased that we have been able to increase our level of research commitment in this area and that while we are working from a small base, we have been able to raise the level of research specifically directed at alcohol and women, from a level of $1 million to $1.7 million in less than a 1-year period. We will continue to place heavy emphasis on increasing services as well as increasing research in the area of women's needs.

In the area of alcohol and pregnancy, we have had a longstanding concern with alcohol consumption, and our research continually has pointed out that alcohol consumption during pregnancy increases the risk of birth defects in offspring. This is a highly preventable area of defects, and at the same time, it is the third leading cause of mental retardation.

The Surgeon General in 1981 issued an advisory on alcohol and pregnancy, advising women who are pregnant or considering pregnancy—as well as nursing mothers—not to drink beverage alcohol. Similar advice has also, more recently, been provided in the dietary guidelines for Americans developed jointly by the Department of Agriculture and the Department of Health and Human Services.

In an effort to assist women to say no to alcohol, NIAAA launched a 2-year National Fetal Alcohol Syndrome Awareness Campaign. As a part of this effort, we have carried out the mandate of the committee to provide mass media messages. We have produced ten public service announcements which have been distributed widely through the National Association of Broadcasters, and we have received well in excess of a quarter of a million dollars of free air time for the provision of these messages.

The Institute's prevention research program is aimed at finding effective and practical measures to reduce alcohol abuse and alcoholism. Progress is being made to establish an increased base of knowledge, and this knowledge is being disseminated and utilized extensively through the States and the local communities.

We will continue to provide and support research in this area to learn what interventions and policy changes, as well as what specific areas of genetics might be most useful to develop specifically targeted prevention programs.

We have been interested in encouraging research which includes the influence of the family as we have continually seen over the years that alcoholism is a disease that runs through families. What we have been particularly interested in finding out and looking at is the effects both of genetics and the environment. The complex interplay between genetics and the environment is evident in many alcoholic families. We will be pleased at the end of the presentation to show you an illustrated diagram of a constellation within a family tree of alcohol-related problems which we are presently attempting to disentangle.

As a part of our prevention efforts, we have been developing a major public education campaign specifically directed at youth before they face substantial peer and societal pressures to drink alcoholic beverages.

The Reader's Digest recently provided information that fourth-graders felt that they were under significant peer pressure to begin drinking. Therefore, we are developing this campaign which will be aimed specifically at young people, preteeners, ages 8 to 12. This will be conducted, as suggested by the subcommittee, utilizing private sector resources—in this case, utilizing the extensive experience available through the Children's Television Workshop—the producers of "Sesame Street", "3-2-1 Contact", and "The Electric Company" who will be developing and implementing this campaign.

Before concluding my testimony, I would like to mention one particular area of research dissemination which we think has been of particular significance. A major area in which we have seen a need for early identification is within the health care system, and primarily within the primary health care provider field, the physicians themselves.

We recently conducted a Conference on "Alcohol, Drugs, and Primary Care Physician Education", to lay out issues, to attempt to provide national leadership, and assist in the development of a better knowledge within the primary care physician field.

As I had mentioned earlier, we are particularly interested in the area of studies of both genetics and environment. We have as one portion of such studies an ongoing study looking at a group of 80 *families which are being studied by our intramural researchers.* We are looking currently at present generations, gathering data on children—we have also gone back and looked at the previous family trees.

The chart which we have provided the committee shows the strong relationship of alcoholism throughout a family. The red squares and circles represent alcoholism running throughout the family. As you can see, through many generations, there are severe problems of alcoholism, as well as other problems, such as the blue markers which represent affective disorders, primarily depression.

What we are interested in looking at in developing leads is not only why alcoholism is running throughout a family, but what preventive aspects can be found. We are particularly interested in knowing why the white markers, which represent children who did not develop alcohol problems, did not develop these problems—what deterred them? We have ongoing studies of families at our intramural lab that are presently looking at the genetic aspects through the utilization of DNA mapping at a molecular level. Also, we are looking at neurophysiological aspects such as brain waves as markers. We are also looking at the environmental factors and looking at the backgrounds of individuals and their families. It is only one of the many exciting areas in which we have research which is providing major leads, both to the Nation, hopefully internationally, in the area of genetics and its impact on the environment.

I would be happy to answer any questions that the committee might have.

[The prepared statement of Mr. Archer follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

For Release Only Upon Delivery

STATEMENT
BY
LORAN D. ARCHER, ACTING DIRECTOR
NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
ON
ALCOHOL RESEARCH PROGRAMS
BEFORE THE
SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
THURSDAY, FEBRUARY 20, 1986

Madame Chairman and Members of the Subcommittee:

It is a pleasure for me to appear here today to discuss reauthorization of the research activities of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). I am particularly pleased to make this appearance with Dr. Jerome Jaffe, with whom I frequently collaborate on the preventable and pressing problems of alcohol and drug abuse in our society.

The revised fiscal year 1986 budget provides funding for NIAAA's research activities at $54.4 million, an increase of $5.6 million above fiscal year 1985. Increased funding for alcohol research during the past several years has enabled us to expand our research into the causes of alcoholism, early identification and treatment, prevention of alcohol-related problems and the relationship of alcohol abuse to major medical disorders, deaths, and injuries. Budget priorities for the coming year include increased support for research in genetics, treatment, and prevention.

In my current position as Acting Director, I would like to thank the Subcommittee for the interest and support it has shown to reducing the problems of alcohol abuse and alcoholism. We appreciate your concern and welcome your assistance as we strive for a better understanding of alcohol abuse, and of alcoholism, a disease which has taken and continues to take a devastating toll on this Nation.

Today, I would like to review with you some of our activities, accomplishments, and plans for the future in research, research dissemination, and prevention.

In addition, you will be pleased to know, we have asked the Institute of Medicine to summarize recent progress in research on alcoholrelated problems and to identify the most promising opportunities for research over the next five years. This study will be conducted by a committee of 10 members with expertise in a wide range of disciplines relevant to alcohol research. It will be completed by the end of calendar year 1986.

GENETICS

Among the significant research developments is the confirmation that alcoholism often has a genetic basis. Further, this genetic predisposition to alcoholism may be accompanied by characteristic physical and biochemical markers that can be detected in the laboratory. These findings hold tremendous potential for the future of alcoholism prevention and treatment. They open the prospect of using genetic markers to identify individuals at risk of alcoholism before the disease is manifested. They also point the way to better understanding of the basic processes that lead to alcoholism. Research is underway to discover exactly which biochemical and cellular mechanisms are altered to create predisposition to alcoholism and what those alterations are.

Knowing exactly what is inherited that makes some individuals susceptible to alcoholism will increase our understanding of its causes. Eventually it should become possible to design new and highly individualized interventions to prevent or treat alcoholism.

I have asked my staff to provide you with a copy of our recent publication entitled Alcoholism: An Inherited Disease. This publication describes some of the significant new knowledge coming out of research on the genetics of alcoholism.

IMAGING

Another research highlight of significance is the new noninvasive technology which is beginning to be applied in studies of the biological effects of alcohol. Among the most powerful techniques are those based on the physical phenomenon of nuclear magnetic resonance (NMR). The diagnostic and research capabilities of NMR are enormous. NMR spectroscopy can provide information about alcohol's effects and allow measurement of changes without the need to open the body or remove tissue. NMR technology will soon become available to NIAAA's intramural scientists located on the campus of the National Institutes of Health. Through use of NMR, we hope to rapidly expand our knowledge of the mechanism of disorders such as liver cirrhosis, cardiac damage, brain damage, the fetal alcohol syndrome, alcohol tolerance, and alcohol dependence.

IMMUNE SYSTEM

Partly because of concern regarding acquired immune deficiency syndrome (AIDS), research activity in the immunosuppressive effects of alcohol is increasing. It has long been known that heavy drinkers are more susceptible to bacterial infection, but little is known about alcohol's effects on resistance to viral infections. For this reason, in November 1985, NIAAA convened a meeting of experts to review current knowledge of the effects of alcohol on the immune system and the possible interrelationships between alcohol and AIDS.

In addition, NIAAA has joined the National Institute on Drug Abuse and the National Institute of Mental Health in a program announcement soliciting applications for grants for research on the alcohol, drug abuse and mental health aspects of AIDS. In the alcohol area, the identified topics of particular research interest include mechanisms underlying the role of alcohol as a factor in cell-mediated immunity and its potential effects on the acquisition of HTLV-III reactivity and the development of AIDS.

As a precaution, many clinicians are now advising individuals at risk of exposure to the AIDS virus to consider life style changes, including the amount of alcohol consumed.

TREATMENT

The alcoholism treatment system has changed considerably over the past decade. These changes include increased availability of third-party payment for alcoholism treatment, expansion of inpatient treatment services, increase in the number of employee assistance programs developed by industry and labor, and the referral of many drinking drivers to treatment programs. At the same time, membership in Alcoholics Anonymous continues to grow. Women, as well as men, are finding it easier to acknowledge an alcohol problem and seek help earlier.

Some notable advances in research have begun to stimulate new approaches to treatment and patient placement. Of particular significance are procedures to measure the severity of alcohol dependence which may soon make it possible to assign patients to different types and intensities of treatment, based on their personal characteristics, needs and prognosis.

Investigation of psychological expectancies, such as beliefs about the disinhibiting effects of alcohol, has shed new light on the complex mechanisms underlying the disruptive effects of alcohol on behavior, particularly in individuals with antisocial personality traits. This knowledge may some day lead to the development of interventions specifically designed to prevent the recurrence of domestic violence, sexual assault, and other types of alcohol-related behavior.

Another area of research advancement is in the identification of alcoholic subtypes. Some evidence suggests that in some individuals, psychopathology and a family history of alcoholism are associated with poor treatment prognosis, and that these types of patients therefore may require more intensive treatment. Other data indicate that married, socially stable patients who develop alcoholism later in life respond better to treatment. This type of patient may be a good candidate for less intensive treatment.

However, there are still many treatment research questions which need to be studied. For example, the relative efficacy of different therapies, the appropriateness of inpatient versus outpatient program settings for different types of patients, the optimal length of stay in residential facilities, and the ideal mix of services ranging from detoxification to aftercare. We will be examining these questions in our research efforts.

Despite such unknowns, it is increasingly clear that health care utilization and costs decline significantly following treatment for alcoholism. For example, in a recent NIAAA-funded study of the impact of alcoholism treatment on utilization and cost of health care by individuals and families filing claims under the Aetna Life Insurance Company's Federal Employee Health Benefit Program, it was found that:

- On the average, alcoholic families used health care services and incurred costs at a rate about twice that of similar families with no known alcoholic members.

- There was a gradual rise in health care costs and utilization by alcoholics during the three years preceding alcoholism treatment, with the most dramatic increase occurring in the six month period before treatment.

- Following the initiation of treatment, the alcoholics' health care costs dropped significantly and eventually reached approximately the same level as that which existed several years prior to treatment (varying somewhat by age group).

- The average cost of reimbursed alcoholism treatment in this population was offset by reduced other health care costs within 2 to 3 years following treatment.

Similar patterns are now emerging from the joint NIAAA-Health Care Financing Administration demonstration project. This project was designed to test the feasibility and effectiveness of alcoholism treatment to Medicare beneficiaries and Medicaid recipients in freestanding residential and outpatient facilities rather than hospitals. Evaluation of the demonstration is still underway, but already it is apparent that in this population (almost half of which was under 65 but disabled), the trend is to greatly reduced utilization of inpatient and outpatient health care following alcoholism treatment.

In addition to its extramural research on treatment, the Institute supports an intramural clinical research program located on the campus of the National Institutes of Health. The clinical program is concentrating its efforts on elucidating inheritance, family system effects, central nervous system and liver effects as well as other complications of alcohol abuse and alcoholism.

ALCOHOL AND WOMEN

In recent years, more and more attention is being given to the effects of alcohol on women. Forty years ago, most women in America did not drink at all, but today more than 60 percent of adult women drink.[1] Nearly 90 percent of college-age women report that they drink alcoholic beverages.[1] Most women who drink do so with no apparent difficulty. But, for some, alcohol can become a problem. Researchers are now recognizing that alcohol is a problem for both men and women and have begun to include persons of both sexes in their research protocols in order to examine the differential effects of alcohol use. In 1984, the Congress directed that special consideration be given to research on alcoholism and alcohol abuse among women. Thus, you will be pleased to know that our grant and contract support for research regarding alcohol and women has increased from approximately $1.0 million in FY 1984 to approximately $1.7 million in FY 1985.

ALCOHOL AND PREGNANCY

Maternal alcohol consumption during pregnancy increases the risk of birth defects in offspring. Defects range from subtle behavioral abnormalities to the severe mental retardation and physical deformities of the fetal alcohol syndrome (FAS). Estimates of the incidence of FAS range from 1 to 3 per 1000 live births.[2] The incidence of less severe alcohol-related birth defects may be ten times higher than the full FAS. Of particular importance for continued research are questions concerning the levels of maternal drinking at which damage occurs and the periods during pregnancy when there is greatest risk.

The Surgeon General, in 1981, issued an Advisory on Alcohol and Pregnancy. It advises women who are pregnant or considering pregnancy (as well as nursing mothers) not to drink beverage alcohol. Similiar advice is included in the 1985 Dietary Guidelines for Americans which were developed by the Department of Agriculture and the Department of Health and Human Services. These guidelines note that the level of consumption at which risks to the unborn occur has not been established and advise pregnant women to refrain from the use of alcohol.

To help women say "no" to alcohol, NIAAA launched a 2-year National FAS Awareness Campaign. The beginning of the campaign coincided with FAS Awareness Week, January 12, so designated by Senate Joint Resolution 189. Most of the campaign activities will be carried out by the States, many of which have launched their own campaigns.

Following the theme of abstinence-during-pregnancy, the Institute has provided television public service announcements to State FAS Campaign Coordinators for wide distribution to local media outlets. These spots were also broadcast via satellite to member stations of the National Association of Broadcasters. Later, I would like to show the announcements to the Subcommittee.

PREVENTION

The Institute's prevention research program is aimed at finding effective and practical measures to reduce problem drinking. There are increasing demands from States, communities, and citizen groups for information on which to build sound, effective prevention programs. There are also major movements at the State level to amend legislation relating to alcohol use and information is needed on the impact of such changes on the incidence of alcohol problems. Progress is being made in establishing a base of knowledge about the prevention of alcohol problems, and this knowledge is being disseminated and used throughout the country.

Research is making it increasingly clear that, given the complexity of factors influencing drinking behavior and the wide range of drinking problems, the most promising prevention strategies are those that combine a variety of approaches targeted both to the individual and to the environment. The Institute will continue research to learn what interventions and policy changes can prevent alcohol-related problems and how these approaches can most effectively be combined into comprehensive prevention strategies. Special emphasis will be placed on studies related to alcohol abuse prevention among adolescents and preadolescents.

YOUTH

Madame Chairman, in view of your interest in children and families, I am sure you would find our research on psychological, cultural, and environmental factors that influence drinking most interesting. Because many alcohol abuse problems develop during adolescence, researchers are studying how young people begin to drink. Use of alcohol can also be associated with many other problem behaviors in young people, such as poor academic performance, juvenile delinquency, school dropout, violence, truancy, running away, depression, and anxiety. Recent data indicate that children are experiencing pressure to use alcohol as early as the fourth grade. We encourage research that considers the influence of the child's family and peer group. Studies are continuing to analyze how children are introduced to drinking and family attitudes, beliefs, and practices regarding drinking. Researchers are looking at controls that may exist within the family to discourage alcohol use by youth, and for those of legal drinking age, to define acceptable/unacceptable behavior with regard to alcohol consumption. The answer to this question may provide new information about the development of alcohol problems.

In the meantime, consistent with Congress' expressed desire that we develop televised public education announcements, the NIAAA is developing a major public education campaign directed at youth between the ages of 8 to 12, before they face substantial peer and societal pressure to drink alcoholic beverages. A professional services firm with extensive experience in prevention, and the Children's Television Workshop (CTW), producers of "Sesame Street," "3-2-1 Contact," and "The Electric Company," have been awarded a 2-year contract to develop and implement this campaign. The campaign will be coordinated with the National Clearinghouse for Alcohol Information.

CTW will design the creative messages and materials to reach the youth audience, their parents and teachers, and others who influence children's attitudes and behaviors. The campaign will rely heavily on the involvement of Federal and State government agencies, national voluntary and professional organizations, corporations, and the broadcast and print media.

One other area I would like to mention today is trauma and its relationship to alcohol.

TRAUMA

Trauma is a major health problem in the United States. Injuries kill more Americans aged 1-34 than all diseases combined, and they are the leading cause of death up to age 44. The total cost of these injuries is more than $75 billion a year.[3] Numerous studies have shown the strong involvement of alcohol in major forms of trauma. With trauma medicine emerging as an important medical specialty, more research is needed in the area of alcohol-related trauma.

For example, additional research is needed on the relationship between alcohol abuse and fractures. One recent study indicated that problem drinkers present fracture patterns resembling those common among the elderly, such as multiple fractures, delayed healing, and reduced bone mass. Another important area where additional research is needed is in the relationship between alcohol and blood loss. Acute blood loss is frequently the cause of death in accident victims, and acute blood loss in intoxicated patients is a common medical emergency. Some studies have indicated that the presence of alcohol decreases survival from an otherwise sublethal blood loss.

In an effort to decrease the number of alcohol-related deaths and injuries on our highways, the NIAAA collaborated with the National Highway Traffic Safety Administration (NHTSA) in supporting 1985's National Drunk and Drugged Driving Awareness Week. Special focus of the activities was devoted to "servers" of alcoholic beverages such as holiday party-givers and bartenders.

Institute staff gathered and disseminated eight public service announcements, a comprehensive activities booklet, a pamphlet containing tips for safe parties and responsible hosting and hostessing, and a series of fact sheets. The materials were developed in cooperation with Federal and State agencies, and public and private sector organizations.

RESEARCH DISSEMINATION

Before concluding my testimony, I would like to mention one of our recent research dissemination efforts. On November 12-15, the NIAAA co-sponsored a conference on "Alcohol, Drugs, and Primary Care Physician Education: Issues, Roles, Responsibilities" at the Annenberg Center for Health Sciences in Rancho Mirage, California. Co-sponsors were the Association for Medical Education and Research in Substance Abuse (AMERSA), the National Institute on Drug Abuse (NIDA); co-hosts were the Annenberg Center for Health Sciences and the Betty Ford Treatment Center of the Eisenhower Medical Center.

More than 100 physicians and medical educators gathered to produce a consensus on the minimal knowledge and skills practicing physicans should have in alcohol and drug abuse, and how to achieve them. Conference proceedings will be distributed widely to professional, academic, voluntary, government and other organizations involved in the effort to combat alcohol and drug abuse.

Madame Chairman, this concludes my formal remarks. I will be happy to answer any questions you may have. But first, with your permission, I would like to show you the public service announcements I mentioned earlier. As you will see and hear, they are directed to a wide range of cultural and ethnic groups.

REFERENCES

1. Alcoholism and Related Problems, The American Assembly, Columbia University, 1984

2. Fifth Special Report to the U.S. Congress on Alcohol and Health, Department of Health and Human Services, December 1983

3. Injury in America, National Academy of Sciences, 1985

Senator **Hawkins**. Thank you, Mr. Archer.

The previous reauthorization required the compilation of a national plan to combat alcoholism, and this model plan was to include among other things a model program for activities to be undertaken by the States and an analysis of the social and economic costs of alcohol abuse to the States. It was to have been completed by October 25th, 1985, and I know you were granted an extension until January 1986.

I understand this study has not yet been completed. I would like to know what the progress is, what is holding you up over there, and how can we get this report out?

Mr. **Archer**. Yes, Madame Chairman. We were particularly pleased with the mandate to provide such a national plan, because we felt it gave us the opportunity to provide a blueprint for the Nation.

We have completed the study. As a matter of fact, the difficulty at the present time is that we are attempting now to pull out of the study a monograph which can be presented to Congress with three major background documents—it is a very extensive study. We are particularly pleased, and we feel that the information that is available in the study will assist the Nation in the next 10 years to make major changes in both prevention and treatment which can significantly decrease the costs resulting from alcohol abuse and alcoholism.

We anticipate that such an decrease can be done utilizing present resources.

What the study has been able to document, among other things, is the fact that we have significant funds being expended in the area of treatment, but being expended ineffectively, and that more effective utilization could double the number of people providing care and significantly decrease——

Senator **Hawkins**. Isn't that old information, though? Isn't that just recycled information? My inquiries to your shop tell me that you have not had time to do it, it is just recycled information, that there is nothing new in this field, and you will get around to it.

Now, I have the responsibility of getting you the money for this Department, and I must say that it does no good to be so slow. We have to respond rapidly. I hope I can get the money faster than you have been able to get the report back to us.

Mr. ARCHER. Madame Chairman, the information is not old information. We have more recent research information. As a matter of fact, the national plan will provide guidance about the direction for research in the future.

We recognize and apologize for the delay. However, we feel that the plan when submitted can provide the guidance to make significant advances in the next 10 years to significantly decrease the rate of problems.

Senator HAWKINS. When will it be finished?

Mr. ARCHER. We would expect it should be submitted for the departmental editing and clearance process within the next month. It is in the editing process within our Institute at the present time, Madame Chairman.

Senator HAWKINS. The previous reauthorization S. 2615—(Public Law 98-509)—required a private sector media effort to warn against drinking while driving and alcoholism. I have seen efforts by the National Highway Safety Administration. Are there any yet by NIAAA?

Mr. ARCHER. Yes, there are three areas in which we are working. One, we have worked closely with the National Highway Traffic Safety Administration; as a matter of fact, we have worked cooperatively with them in the development and distribution of PSA's and the other printed materials for "Drugged and Drunk Driving Awareness Week".

The second area is the entire area of the Fetal Alcohol Syndrome for which we have developed several public service announcements and provided them to the States.

The third area is the one which we will be implementing in April 1987. We specifically have delayed development of our preteen campaign until that time, so as to coordinate it with NIDA's "Just Say No" program, which will be phasing down at that point in time. We will complement the NIDA program. We have attempted to work closely with NIDA so as to coordinate campaigns.

Senator HAWKINS. That is where you spent the money? Did you spend the money?

Mr. ARCHER. Yes.

Senator HAWKINS. In coordination with the highway transportation?

Mr. ARCHER. We have provided them with PSAs; we have worked with the States, and spent it on highway safety and Fetal Alcohol Syndrome campaigns, and we are presently underway in the development of a major campaign which will be aimed at preteens.

Senator HAWKINS. And when does that come out?

Mr. ARCHER. April 1987.

Senator HAWKINS. Why take so long? Do you know I can hire a man in the morning and have a commercial by evening?

Mr. ARCHER. We could as well, but——

Senator HAWKINS. Well, why not?

Mr. ARCHER. Well, a concern we had in coordinating with NIDA was that we did not want to be in competition with the "Just Say No" program in terms of the air time which would be made available by the networks.

No. What we are saying is that the "Just Say No" program will be phasing down at that time. Then we will come back to seek the same level of air time and to complement the NIDA program. And just as they agreed to include alcohol as a part of the "Just Say No", we will——

Senator Hawkins. So we did this in 1984, and you are going to have a program in 1987.

Mr. ARCHER. Yes, we will—although I must re-emphasize that we have had media programs in the areas of Fetal Alcohol Syndrome and highway traffic safety.

Senator HAWKINS. I must say it is going to do much harm, I believe, in your drive to be cut loose from this oversight committee and with reauthorization bumping into you every 2 years, you still have not performed even under the jurisdiction of this subcommittee.

I am just wondering is there any truth to the reports we read that we are close to finding a link between alcohol and AIDS, or is that just newspaper talk? I have read a lot of that lately that is untrue. I wonder whether the AIDS and alcohol is true or not.

Mr. ARCHER. The present level of information that we have received from the present research indicates that while there may well be a cofactor relationship, there is no indication of a specific cause-effect relationship between excessive alcohol use and AIDS. What we are particularly interested in is additional information about what is the extent of alcohol as an immunosuppressive agent. We do know it affects bacterial infection. We have limited knowledge from the research on viral infections.

Senator HAWKINS. Before we go to Dr. Jaffe, I would like to welcome Senator Dodd.

How are you, Senator? You do not sound very well.

Senator DODD. No, like everyone else, I am fighting a cold.

Senator HAWKINS. Would you like to go to Duke? [Laughter.]

Senator DODD. No.

Senator HAWKINS. It is a great place.

Senator DODD. If I understood you here, I have been looking over some of the testimony this morning, and I think I heard Senator Hawkins express her concerns about the amount of time it would take. I am looking at page 12 of your testimony here, and is this what we are talking about here—"Consistent with Congress expressed desire that we develop televised public education announcements, the NIAAA is developing a major public education campaign directed at youth between the ages of 8 to 12 . . .," and so forth. "A professional services firm with extensive experience in prevention . . . have been awarded a 2-year contract to develop and implement this campaign."

Is that what we are talking about?

Mr. ARCHER. Yes, sir.

Senator DODD. Well, I find that a little long, too. I am not so sure—in fact, I am uneasy about people who tell me they can produce a spot overnight. And I realize, you know, we are going to put a lot of money into this kind of thing. In fact, I would love to see what we could do to help in Connecticut; I suppose maybe you want to gear these to different audiences. But 2 years is an awful long time to get that campaign off the ground. What is the reason for that?

Mr. ARCHER. Senator Dodd, as I mentioned earlier, we are anxious to get the campaign underway as well, but we thought it would be inappropriate to place out a campaign that would appear to be in conflict with our sister Institute, NIDA's, campaign on "Just Say No." So we have worked with NIDA for the inclusion of alcoholism messages in their campaign. We will then produce our campaign when theirs is phasing down in 1987. We will include drug messages in our campaign as well.

We could have moved far more rapidly, and we would have liked to. But if we did, the impression and the information that we received from the broadcast industry——

Senator DODD. Well, is this some interagency competition we have got going on?

Mr. ARCHER. No. As a matter of fact, what we are attempting to do is not have competition but to supplement their campaign, so that when their funding for public messages is down, we will increasing our funding——

Senator DODD. Well, then, why don't we just wait for them? What is the point of a 2-year study?

Mr. ARCHER. Well, Senator, there is no 2-year study. It was merely waiting until their campaign is phasing down to implement ours.

Senator DODD. Well, "a 2-year contract to develop and implement this campaign." What are we paying for that? How much is that costing?

Mr. ARCHER. I can provide the committee with the exact dollar information. The 2 years is the period in which the campaign will take place.

[Information subsequently supplied for the record follows:]

The NIAAA has initiated a major public education campaign directed at youth aged 8 to 12—before they face increasing peer and societal pressures to drink alcoholic beverages. In fiscal year 1985, $355,000 was awarded to Macro Systems, Inc., a Silver Spring, Maryland-based professional services firm with extensive experience in prevention, and the Children's Television Workshop (CTW), producers of "Sesame Street," "3-2-1 Contact," and "The Electric Company." An additional $500,000 will be awarded in fiscal year 1986.

CTW will design the creative messages and materials to reach the youth audience, their parents and teachers, and others who influence children's attitudes and behaviors. As the prime contractor, Macro Systems, Inc., will work closely with NIAAA and CTW to make this campaign a comprehensive public/private sector partnership. The campaign will rely heavily on the involvement of Federal and State government agencies, national voluntary and professional organizations, corporations, and the broadcast and print media.

The Children's Television Workshop has long been considered the premier creative force in using television and supporting channels to inform and educate young people.

Senator DODD. Well, that is not very clear in that paragraph. My impression on reading it is that it is a 2-year contract to develop and implement the campaign, and that it is going to take that long before it goes into effect; and that you are saying to me that you do not want to have a program that overlaps what NIDA is doing, so you are going to wait until they complete their program, and then you will be ready to trigger in your program. Is that right?

Mr. **Archer**. That is correct, yes. As a matter of fact, we have already provided promotional messages to the various broadcasters throughout the Nation from the Children's Television Workshop, as to when the campaign will start and when the materials will be available.

Senator **Dodd**. Well, let us get some clarity on that, OK? I would like some more on that. I am not quite sure what you are getting at.

Mr. **Archer**. We would be pleased to provide that to the committee.

Senator **Dodd**. Again, in this day and age, I could take you to drug rehabilitation centers in Connecticut where you simply bring the camera crew in and get testimonials of kids, that I think would be tremendous spots. You do not have to get terribly glitzy about these things.

Mr. **Trachtenberg**. Senator, I would like to add two perspectives to that for both you and Senator Hawkins to consider. I am Robert Trachtenberg, the Acting Administrator of ADAMHA.

The first is that there is tremendous competition in the television broadcast areas for public service announcements. Everyone wants to get their public service announcements on the air.

One of the things that we are concerned about when we talk about competition is that we not overwhelm the TV markets, particularly in competition with other worthy public service announcements, including those of a sister institute, that these choices have to get made. So we try to time our media campaigns in the most appropriate way possible, because you lose tremendous effect otherwise, if the broadcast managers have to make those kinds of decisions.

The second thing is that this is serious business, because when you put out a message, you have got to make sure it is the right message, because I think too many times in the past, we have put out the wrong message, and it has been interpreted wrongly by young people.

So it is not just a matter of quick, down and dirty, putting together a script and putting out a message. You have to make sure from a research base, from a science base, generally, that this is something that people are going to believe, and that the right response is going to happen.

Senator **Hawkins**. Let me interrupt you just a moment. I am the author of that bill, and as I recall, it was for prime-time purchasing. I am sick of seeing PSA's at 11:30 or 12:30 at night. Now, there is no conflict at midnight with something I want to see at 6, or 5:30 or 7. Now, you may not have been here at the time when we passed that, but that was the primary purpose: to purchase and put on prime-time some wonderful things I might see at midnight. But it was prime-time, That is when we want to talk to these kids.

I agree with Senator Dodd. We could maybe take the money back and just get a camera right there—that handsome lad over there, who is nodding that he would be glad to go to Florida; it is too cold in the North, so let us go South this time——

Senator **Dodd**. Do you mean this is not NBC or ABC?

Senator **Hawkins**. I do not know. He just said he would like to go. [Laughter.]

And all your people are in Florida anyway, this time of year.

Senator **Dodd**. The Irish never go to Florida. [Laughter.]

Senator **Hawkins**. But we could interview these kids. There is nothing like the mail I get. Nothing like the kids I talk to. It is an absolutely phenomenal education. I am tired of waiting for the details and statistics, and watching wonderful stuff at midnight. This is prime time, and I want you back on track.

Mr. **Trachtenberg**. I understand that, Madame Chairman, and that is what we intend, and I think you are going to see a tremendous product coming from the Children's Television Workshop.

Senator **Dodd**. I just hope we can get a little more clarification on it—it is, to say the least, a little vague—and some numbers. I would like to know what the cost is for that. We get very sensitive to costs of these things, and I would be curious as to what the costs are with that.

Madame Chairman, I have an opening statement, and I would just ask unanimous consent to include it in the record, and just note that, as you know, in Connecticut, there was a study done by a wonderful individual who has been deeply involved in these programs for almost 20 years. But one out of every five people arrested in Connecticut is a child who has been involved in narcotics abuse. One out of four in a survey of high school students in Connecticut are taking alcohol once a week.

I do not know how those statistics compare nationally, but they are growing in numbers, and that is what you can glean out of it. It may be even worse than that.

So these programs that you can put on—I do not know how—obviously, it is important they be done well, and I hope you do not misinterpret what Senator Hawkins and I are saying. We are not talking about doing something overnight, either. We understand that it is very important it be done well if it is to work. And obviously, you are doing it with taxpayer money. We want it to be effective.

And you know what we are talking about. You can get a bunch of wizards you pay a lot of money to for 2 years, and we go through it in a minor capacity, but this does not need to take that long. Good people can produce a good product in a relatively short period of time—if they know what they are talking about, they know where the audience is and what the message ought to be.

So that is really the only point we are making to you, and it should not be misinterpreted as something where we want you to go out tonight and do a fast spot somewhere on the corner, to throw it on television regardless of the impact it has.

Mr. **Trachtenberg**. Both of your points are abundantly clear.

Senator **Dodd**. Thank you very much.

Thank you, Madame Chairman.

Senator **Hawkins**. Dr. Jaffe.

Dr. **Jaffe**. Madame Chairman and members of the subcommittee, I appreciate your invitation to appear before the committee today and to discuss the reauthorization of the research program at the National Institute on Drug Abuse.

I will be submitting a full statement for the record, but at this point I would like to try to summarize my statement.

The number of Americans using illicit drugs remains near the historic high levels which followed the dramatic increases in use during the period between 1969 and 1979. But the use of some drugs such as cocaine is, in fact, increasing. And further, between 1981 and 1984, there was a threefold increase in the number of emergency mentions of cocaine and of medical examiner reports of cocaine-related deaths.

Since our last reauthorization, a new drug phenomenon has emerged—the so-called "designer drugs" or "controlled substances analogs." There is some evidence that youth are experimenting with drugs at an earlier age than was the case in 1975.

Further, as a result of needle-sharing, a high percentage of intravenous drug users are now carriers of the AIDS virus, and these users can then transmit the deadly virus to their sexual partners, and in the case of pregnant women, to their children.

Further, drug use by persons in key jobs affecting health and public safety is a growing concern, as is the role of drugs in decreasing productivity among workers in general.

NIDA is one of 30 Federal agencies involved in the overall efforts to reduce drug use, and NIDA's current role is to develop and disseminate new knowledge about drug abuse and its prevention and treatment, and to exercise leadership in encouraging and assisting other Federal agencies in the private sector in implementing and supporting intervention, prevention and treatment programs.

NIDA's research program has several components. Epidemiology is one. The Institute has developed a unique capability for reliably assessing the nature and extent of the Nation's drug abuse problem and its trends over time. I think our epidemiology program in drug abuse is the best in the world

About half of NIDA's extramural research programs consist of basic research, which seeks to develop new knowledge about the mechanism of action of drugs, and their sites of action. Other research focuses on the hazards of using various drugs. And still other research focuses on ways to develop assay methods for detecting drugs in body fluids. These have had great practical use in both law enforcement and more recently, for businesses concerned about drug use by their job applicants and employees.

NIDA's current prevention research program includes several broad areas. These include research on the causes of use and abuse; research on trends in use; research on the abuse potential of new drugs; research on the risks and consequences of using drugs—this kind of information is used in prevention programs—and research on methods of prevention and early intervention, which looks at how effective different prevention programs are in deterring or delaying the onset of drug abuse behaviors.

The treatment research program at NIDA is focused on those persons who are already heavily involved in drug abuse and who are suffering the consequences of that involvement. This kind of effort involves us in some rather complex research, because the kinds of people who become drug-dependent are heterogeneous, and therapy must be matched to the needs of the individual patients.

Among the high priority areas that NIDA has been involved in over the last several years has been the institution of demonstration programs for prevention and treatment. Wherever possible, our efforts to look at prevention and treatment focus on those activities which are practical and are already being used in the field.

For example, in the area of prevention, researchers are involved in such projects as testing a primary prevention model of cognitive skill building with adolescents and their parents and investigating the long-term effects of a multi-factor program to prevent the onset of tobacco, alcohol, and marijuana use among junior high school students.

In the area of treatment, researchers are evaluating the efficacy of a prison-based therapeutic community; assessing the efficacy of a 6-month program of recovery training and self-help for cocaine abusers; and comparing the effectiveness of three different treatment approaches, including family therapy in treating adolescent drug abusers.

NIDA has particularly given emphasis to programs and needs of drug-abusing women and their offspring, and each Division within NIDA has had continuing efforts underway to increase its commitment to address problems which affect women and their offspring.

Cocaine has been another new and major focus of our research. In 1984, for example, the Institute funded approximately 23 grants related to cocaine and other stimulants.

The use of "controlled substance analogs," which have the unfortunate street name of "designer drugs," is yet another area of new research and emphasis at NIDA that has taken place over the last several years. NIDA-funded researchers, for example, have demonstrated the neurotoxicity of one class of these drugs related to the methamphetamines, which includes both MDA and MDMA, known on the street as "Adam" and "Ecstasy," respectively.

Last, NIDA has been gravely concerned about the relationship between intravenous drug use and AIDS, and we have initiated major programs in this area.

NIDA recognizes fully that gathering information is not sufficient. It is also necessary to get information to the public, and to the researchers, and to the treatment staff who can use it. Therefore, we have made special efforts in the area of information dissemination.

In addition to monographs and other publications, NIDA has developed a number of other mechanisms for disseminating knowledge to the field. For example, we have held a number of symposia and workshops around the United States to disseminate research-based treatment knowledge to practitioners in three areas: the treatment of cocaine dependence; the treatment of adolescent substance abuse; and aftercare/self-help services.

During the past 3 years, NIDA has been involved in two major national media campaigns designed to get the most accurate and current information about drug abuse to carefully targeted audiences. The 1983–85 NIDA drug abuse prevention media campaign was developed to reach parents and young people with drug abuse prevention messages through a broad range of media materials. This campaign had the major theme of "Just Say No." It was integrated into radio and television public service announcements, distributed to broadcasters nationally, and into print media distributed to organizations and agencies throughout the country.

In 1985, we launched phase 2 of this highly successful campaign by expanding its target audiences to include minority, inner-city young people, ages 10 to 14, and their families. I might point out that at the end of my statement, if time permits, we have a video to show which was designed to reach this inner-city group of teenagers.

NIDA will shortly be launching another major media campaign, focused on cocaine The campaign's primary audience will be young people, aged 18 to 35, including those working and in college.

At this point, I would like to answer any questions you may have after you have seen our video, or if time does not permit, before you have seen our video.

Thank you very much.

Senator HAWKINS. Thank you, Dr. Jaffe.

[The prepared statement of Dr. Jaffe follows:]

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To Be Released Upon Delivery

Statement of

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before the

Subcommittee on Children, Family, Drugs and Alcoholism
Committee on Labor and Human Resources
United States Senate

on

The Reauthorization of the National Institute on Drug Abuse

Thursday, February 20, 1986

10 A.M.

Room 430, Dirksen Senate Office Building

Madame Chairman and Members of the Subcommitee: I appreciate your invitation to appear before the Committee today to discuss reauthorization of the research program of the National Institute on Drug Abuse (NIDA). Before describing the various components of our program, I would like to briefly discuss the extent of the drug abuse problem in the United States and our role as the leading Federal agency in the area of demand reduction.

Nature and Extent of the Problem

Drug abuse is one of the most serious problems facing the United States today. The number of Americans using illicit drugs has stabilized, but remains near the historic high levels which followed the dramatic increases in use during the period between 1969 and 1979. The use of some drugs is, in fact, still increasing among certain groups within the population. For example, the 1985 High School Senior Survey, funded by NIDA and carried out by the University of Michigan Institute for Social Research, found that cocaine use by these young people increased in 1985 among virtually all of the subgroups examined. These included both males and females, the college-bound and the non-college bound, and students from rural and urban areas in all regions of America except the South. Data from NIDA's Drug Abuse Warning Network (DAWN) show that between 1981 and 1984 there was a threefold increase in the number of emergency mentions of cocaine and of medical examiner reports of cocaine-related deaths.

As you are well aware, since our last reauthorization, a new and very frightening drug phenomenon has emerged--which the Congress has very properly called "controlled substances analogs," but which unfortunately are still known to most of the public by the potentially glamorous and enticing name of "designer drugs." These drugs, which are created by underground chemists by slightly altering the molecular structure of scheduled drugs, have great potential for seriously undermining the health and safety of the American public. Individuals exposed to these drugs, some of which are hundreds of times more potent than morphine or heroin and many of which contain toxic impurities, are at risk for suffering crippling side effects such as permanent disability from brain damage, or even death. Fortunately, the incidence and prevalence of their use have not been large, so far, and the Congress has moved quickly to close the loopholes in the Controlled Substances Act and has prohibited their manufacture and sale.

We are also disturbed by the evidence that youth have been experimenting with drugs at younger and younger ages since 1975. For marijuana, alcohol, and cigarettes--the "gateway drugs"--the average age at first use now is at the junior high school level. While drug abuse rates vary from community to community and there are some differences in the extent and pattern of use by sex, race-ethnicity, and social class, no group has been found to have an immunity.

Drug abuse does more than threaten the health and social well being of the individual user. To take a very dramatic example, as a result of sharing needles, a high percentage of intravenous drug users are now carriers of the AIDS virus; these users can then transmit the deadly virus to their sexual partners and, in the case of pregnant women, to their children. Drug use also has been found to be highly correlated with both violent and nonviolent crimes by juveniles and adults. Drug use by persons in key jobs affecting health and public safety is a growing concern, as is the role of drug use in decreasing productivity among workers in general.

NIDA's Role

Drug abuse is a complex and far-ranging problem and calls for an equally complex and comprehensive response. Today, more than 30 Federal agencies, State and local governments, and a wide range of organizations and individuals in the private sector are actively involved in efforts both to reduce the supply of drugs available to our citizens and to reduce the demand for them. NIDA's efforts are a significant part of this multi-faceted approach to reducing drug abuse and its personal and societal costs.

With the passage of Title XX of Public Law 97-35 (The Alcohol and Drug Abuse and Mental Health Services Block Grant) in 1981, full responsibility for carrying out treatment and prevention service functions was transferred to the States. NIDA's current role, which was set forth in the Alcohol and Drug Abuse Amendments of 1983 (Public Law 98-24) and is now being considered for reauthorization, is to develop and disseminate new knowledge about drug abuse, its prevention and treatment, and to exercise national leadership in encouraging and assisting the private sector, the States, and local governments to implement and support prevention, intervention, and treatment programs in their communities. In addition, NIDA's research on the abuse liability and risks associated with specific drugs support the supply reduction program by providing the information necessary to control drugs under the Controlled Substances Act.

NIDA's Research Program

NIDA's research program has several important components. Through its epidemiological research program, the Institute has developed a unique capability for reliably assessing the nature and extent of the Nation's drug abuse problem and its trends over time. In order to track the incidence and prevalence of drug abuse, NIDA supports two ongoing epidemiological surveys, the National Household Survey on Drug Abuse and the High School Senior Survey. NIDA's Drug Abuse Warning Network (DAWN) monitors information on the negative health consequences of drug use through emergency rooms and medical examiner reports. In addition to these major efforts, NIDA also supports a number of special epidemiological studies.

About half of NIDA's research program consists of basic research, which seeks to develop new knowledge about the mechanism of action of drugs, their sites of action, especially in the brain and central nervous system, and their pharmacology. Recent advances in receptor research under sponsorship of NIDA grants have done much to advance our basic knowledge about how drugs act in the body and how their effects are produced. Other research conducted by NIDA focuses on the hazards of various drugs, ranging from the adverse biological effects of drugs on body systems to their psychobehavioral effects on learning, performance, and cognition and their social effects. From this type of research we have learned, for example, that acute intoxication with marijuana interferes with many aspects of mental functioning and poses a major impediment to classroom performance. The drug also has serious acute effects on perception and coordination performance, both of which are involved in driving and many of the tasks of daily living.

NIDA-funded scientists are also involved in the development of new compounds, the prediction of drug action, the determination of metabolic pathways of drugs, and the development of assay methods for detecting drugs in body fluids. This last area has had great practical use for law enforcement agencies and for businesses concerned about drug use by their job applicants and employees. Early next month, NIDA is sponsoring a conference on Drug Abuse in the Workplace which will highlight the most current information on various drug detection technologies and will bring together a wide range of companies to discuss how these technologies can best be used both to safeguard the public and to help drug abusing individuals.

Research in all of these areas is conducted both through extramural grants and contracts and at NIDA's intramural research facility, the Addiction Research Center or ARC. In 1985, the ARC, which began as the research division of the U.S. Narcotic Farm in Lexington, Kentucky, celebrated its 50th anniversary and the dedication of its new facilities in Baltimore. The ARC represents the largest single interdisciplinary team working on these problems of drug abuse. It employs neuroscientists, analytic chemists, biochemists, pharmacologists, behavioral pharmacologists, psychologists and psychiatrists. They work on problems ranging from effects of drugs on the immune system to the psychological responses to cocaine withdrawal.

Prevention and treatment research are a major part of NIDA's research program. NIDA's current research program in support of prevention includes several broad areas: (1)research on causes of use and abuse; (2)research on trends in use; (3)research on the abuse potential of drugs; (4)research on the risks and consequences of using various drugs; and (5)research on methods of prevention and early intervention. The first area of research seeks to expand understanding of the factors that inhibit or contribute to the risk of drug abuse in later life. Better understanding these factors, or the etiology of drug abuse, assists substantially in the development or refinement of preventive interventions. The second area, research on trends in use, helps identify prevention priorities and enables prevention programs to target high risk groups. The third area, research on abuse potential of drugs, permits the development of appropriate guidelines for the use of drugs and permits the scheduling of certain drugs in order to restrict access to them. The fourth area, research on the risks and consequences associated with particular drugs, provides the information necessary in the development of accurate information on drug abuse central to so many prevention efforts. The final area, preventive intervention research, looks at how effective different prevention programs are in deterring or delaying the onset of drug abuse behaviors. This research focuses on youth, since adolescence is the time during which most drug use is initiated.

The treatment research program at NIDA is focused on those persons who are already heavily involved in drug abuse and who are suffering the consequences of that involvement. In recent years, there has been a substantial increase not only in the number of casual users and of dependent individuals, but in the variety of drugs they are using. Multiple drug use has become the rule rather than the exception. As patterns of drug abuse have become more diverse and complex, finding the most effective treatments has become a much more complex task. In addition, as with other biobehavioral problems, the population seeking treatment for drug abuse is heterogeneous. The individuals vary along demographic dimensions such as social class, age, employment, and other drug experiences. To further complicate the problem, psychopathology is often associated as an antecedent to or consequence of substance abuse. Thus, there is a need to match the therapy with the needs of the patient.

NIDA has concentrated its treatment research efforts on the development of innovative, effective, and cost efficient therapeutic approaches. Recent areas of emphasis included interrelations between drug abuse and other biobehavioral disorders (e.g., eating disorders and stimulant abuse), special problems related to particular agents (e.g., cocaine) or forms of drug abuse, development and evaluation of new agents used as adjuncts in treatment (e.g., LAAM, naltrexone, nicotine gum), as well as the complex interactions between behavioral, pharmacological, and treatment variables in determining long-term outcome.

Demonstration Projects in Prevention and Treatment Research

Whenever possible, the Institute attempts to focus proposed prevention and treatment research efforts (particularly those which evaluate the effectiveness of various strategies) on interventions actually being used in the field. For example, in the area of prevention, researchers are involved in such projects as: testing a primary prevention model of cognitive skill building with adolescents and their parents; investigating the long-term effects of a multi-factor program to prevent the onset of tobacco, alcohol, and marijuana use among junior high school students; looking at the differential effectiveness of two prevention strategies among 7th graders in high and low risk schools; and testing the impact of various message styles and formats on the effectiveness of drug abuse prevention literature and media campaigns aimed at teenagers.

In the area of treatment, researchers are evaluating the efficacy of a prison-based therapeutic community; assessing the efficacy of a six-month program of Recovery Training and self-help for cocaine abusers; comparing the effectiveness of three adolescent treatment conditions, including family therapy; and determining the effectiveness of psychotherapy for high severity opiate addicts enrolled in a methadone maintenance program.

Special Areas of Research Emphasis

In addition to these ongoing areas of NIDA's research, there have been a number of special areas of research emphasis since the last reauthorization. For example, NIDA has focused on the particular problems and needs of drug-abusing women and their offspring. Each Division in NIDA has continued efforts under way dealing with drug abuse and women and has been planning for new activities in this regard. Specifically, we have geared our data systems to look at gender as a variable, and we plan to do retrospective and current reports on race and gender differentials on our survey data. We also plan to supplement existing grants to include women in studies on drug abuse and violence (victims and perpetrators).

We are soliciting applied research grants to study gender differences on smoking and addiction; PCP and cocaine gender differences; and prevention and intervention in drug use, misuse and abuse by women. In addition, we are publishing findings from review papers and roundtable discussions resulting from a technical review on teenage single parents and drug abuse, as well as a monograph based on the May 1985 Technical Review, Women and Drugs: A New Era of Research.

Some of our long-standing grant projects have to do with the effects of various drugs in women, the methods of detoxifying women who are addicted to heroin, and the outcome of women and men treated in traditional drug modalities. Our own intramural research program at the ARC is planning to admit, on a pilot basis, two or more women who will remain in residence with other subjects in a study of marijuana's effects on biological and immune systems.

In the technology transfer arena, NIDA has developed a bibliography on women and drug abuse and a mailing list of programs interested in this area, and has been working on an Alcohol, Drug Abuse, and Mental Health Directory on Treatment and Prevention Resources for Women. In addition, we have been conducting women and drug abuse workshops at national conferences to transmit research findings on treatment and prevention to State and local policymakers and service providers. We are also working on implementing recommendations from a Public Health Service task force on women and health.

Cocaine, which is not only an extremely dangerous and addictive drug, but one of the few which is increasing in use, has been another focus of our research. We regard cocaine as a significant public health problem, both in terms of the number of users and the serious adverse consequences for which these users are at risk. In addition to its continuing efforts to track trends in cocaine use and to refine our data sources to get an even more accurate picture of the dimensions of the problem, NIDA is devoting an increasing proportion of its resources to research aimed at understanding exactly how cocaine works, what its effects are, and what treatment and prevention approaches are most efficacious in dealing with this particular drug. In 1984, for example, the Institute funded approximately 23 grants related to cocaine and other stimulants. A number of important findings have emerged from our research on cocaine. We now know, for example, that cocaine is one of the most powerfully addictive drugs, exerting its effect by acting directly on the reward or pleasure centers of the brain. This action produces an intense desire to experience the effects of cocaine again. Cocaine's positive reinforcing properties have been demonstrated in every species of animal tested. In addition, if access to the drug is not limited, there is evidence that some animals will self-administer cocaine to the point of toxicity and death, selecting cocaine in preference to food and water. By contrast, animals will not self-administer opiates, even heroin, to the point of such toxicity.

To encourage additional research, in 1984, NIDA distributed a new research announcement to the field inviting applications for studies to broaden understanding of cocaine use and help identify effective strategies for treatment and prevention. This research is to focus on a number of areas, including etiology, biomedical aspects, neuroscience, behavioral pharmacology, treatment, and prevention. This represents a significant expansion in our research portfolio on cocaine.

Last year, NIDA published Cocaine: Pharmacology, Effects, and Treatment of Abuse. The monograph discusses the scientific evidence that cocaine is powerfully addictive and describes how it activates reward circuits in the brain. It also discusses current and experimental treatment for cocaine abuse. In July of 1984, NIDA held a national symposium on cocaine for the purpose of developing a comprehensive description of patterns and consequences of cocaine use in this country. Prominent clinicians, researchers, and epidemiologists presented papers which were published in another monograph entitled Cocaine Use in America: Epidemiologic and Clinical Perspectives, which was released in early Fall, 1985.

Research into the treatment of cocaine abuse has become an important priority area for NIDA. We have learned a good deal about several approaches which work for many individuals. These include psychotherapy, behavior modification, self-help strategies, and various pharmacotherapies.

The use of controlled substances analogs, which as I noted earlier have the unfortunate street name of "designer drugs," is another area of new research emphasis at NIDA during the past several years. In recognition of the danger that these drugs pose, NIDA is supporting a number of research projects that are designed to: detect and monitor the use of these drugs and the extent to which the use spreads to other geographic areas; assess the basic mechanism of drug actions, toxicity, and clinical pathology; determine more precisely the health consequences of using these drugs; and disseminate information to the medical community, treatment and prevention programs, and to the public at large. For example, NIDA-funded researchers have demonstrated the neurotoxicity of one class of these drugs--the methamphetamines--which includes both MDA (known on the street as "Adam" and MDMA (or "Ecstasy"). They have also learned that the dose of these drugs that produces psychological effects is not far removed from the dose needed to induce neural damage, and thus we believe it very possible that the individuals abusing these methamphetamine derivatives are indeed inducing brain damage.

In the last few months, as the result of an interagency agreement between NIDA and the Drug Enforcement Administration (DEA), NIDA has carried out syntheses of 14 designer drugs. The production of these compounds provide a valuable source of materials for abuse liability testing and other research by NIDA grantees and will assist DEA's enforcement efforts by providing the pure standards so critical to forensic lab analyses in confiscation cases.

Last--but definitely not least--NIDA has been gravely concerned about the relationship between IV drug abuse and AIDS. Based on national data, approximately 65 percent of the cases of AIDS are among non-IV drug-using homosexual men, 8 percent are among homosexual IV drug users, and approximately 17 percent are among heterosexual intravenous drug users. Put another way, individuals with a history of intravenous drug use make up approximately 25 percent of the total number of reported AIDS cases. When we look at certain areas of the country, the relationship between IV drug use and AIDS is even more dramatic. For example, in the New York area, 38 percent of reported AIDS cases are among those with a history of IV drug use. Pediatric cases represent less than 1 1/2 percent of the total AIDS cases; however, 52 percent of these children are the offspring of IV drug users. Many people also fail to appreciate that there are significant numbers of women who are developing AIDS or are infected with the AIDS virus; many of these are women with a history of using intravenous drugs.

NIDA's activities in the area of AIDS have focused on three principal populations: drug users currently infected with the AIDS virus; other drug users at high risk of and concerned about the disease; and drug abuse treatment and service providers. In the area of research, we are continuing support for studies which seek to determine the relationship between the effects of various drugs of abuse on the function of the immune system. We are also encouraging studies to develop and expand our understanding of the epidemiology of AIDS. These will focus on the etiology, risk-factors, and natural history of AIDS among populations at risk for developing the disease due to drug abuse or contact with drug abusers.

Education and prevention programs targeted at several audiences are another major element of our strategy. Clearly, drug users, particularly IV drug users, need to know about the risks to themselves, their sex partners, and families when they use IV drugs. Right now we have no way of predicting which individuals carrying the virus will develop AIDS. At present, it appears that over a 5-year period approximately 5 to 10 percent of those infected with the virus will go on to develop AIDS, and 20 to 25 percent will probably develop AIDS-related complex. We have reason to believe that the IV drug user who uses frequently is at greater risk than one who uses infrequently. Nevertheless, even the occasional user of IV drugs, whether heroin, cocaine, amphetamines, or some other substance, is at risk for contracting the virus and subsequently AIDS itself. This point must be stressed and is the cornerstone of our efforts in prevention and education regarding AIDS and IV drug use.

We are developing and disseminating information to specific high risk subgroups and the general public about the relationship between drug abuse, the spread of the AIDS virus, and the risks for subsequently developing AIDS. A "NIDA Capsule" or fact sheet on the subject of AIDS and drug abuse has been developed and has been distributed both to the press and to State drug abuse agencies. It describes AIDS, the methods by which the disease is transmitted, and specific ways to reduce risk of infection with the virus. Other publications are being planned, including flyers, booklets, and posters to be printed in both English and Spanish.

We are undertaking a number of other activities aimed at better informing treatment and service providers about suitable procedures for serving drug abuse clients infected with, or at-risk for becoming infected with the AIDS virus. We have developed a repository of findings and materials about AIDS and IV drug use and have initiated monthly mailings to State agency directors of recent findings and new materials that may be useful in planning service delivery and prevention activities.

It is important to address the fears of both the clients and the staffs of drug abuse treatment programs. Training materials and programs are being developed for State drug abuse agencies, drug treatment programs, criminal justice detention systems, and other relevant health care agencies which encounter IV drug users and/or their families. A series of workshops will be held during the next several months to discuss such topics as: AIDS and the drug abuse treatment environment; counseling clients exposed to the AIDS virus, whether or not they are symptomatic; and treatment of these clients in residential programs. Though specific procedures and policies will of course have to vary from State to State, we hope to establish consensus around a number of issues. NIDA will also provide on-site technical assistance on AIDS and drug abuse to drug abuse treatment programs.

Dissemination

As the description of our AIDS activities demonstrate, NIDA's national leadership role goes beyond its lead role in funding and carrying out drug abuse research. A major part of the Institute's mission is to provide guidance and assistance to drug abuse prevention and treatment efforts at the State and community levels. In carrying out this responsibility, NIDA pursues a number of different, but related activities. They include: technical assistance to groups in both the public and private sector; identification and--through limited funds for demonstration projects--replication of model prevention and treatment programs; dissemination of prevention and treatment research findings to schools, parents groups, primary health care providers, and law enforcement personnel through publications and workshops; and public education through the development of written information and national media campaigns.

All these elements of the Institute's overall demand reduction strategy build on the knowledge gained through its research activities. For example, as important as we consider our recent research on cocaine treatment, it is equally important that we disseminate the results of that research to the practitioners who can make use of them. In addition to monographs and other publications, NIDA has developed a number of other mechanisms for disseminating knowledge to the field. For example, during 1985, NIDA held a series of symposia--in Portland, Boston, Atlanta, Los Angeles, New York, Dallas, and Chicago--designed to disseminate research-based treatment knowledge to practitioners. Each symposium had three workshops: Treatment of Cocaine Dependence; Treatment of Adolescent Substance Abusers; and How to Provide Aftercare/Self-Help Services. In April 1985, in Milwaukee, the Wisconsin Institute on Drug Abuse and the Tellurian Society, with NIDA as co-sponsor, held a national symposium on cocaine. Surgeon General Dr. C. Everett Koop gave the keynote address on "Cocaine and Health," and former NIDA Director Dr. William Pollin spoke on the topic of "Cocaine--A Powerfully Addictive Drug." Other NIDA staff and a number of NIDA-supported researchers presented information on current activities and findings in cocaine research, prevention, and treatment. More than 400 health professionals, law enforcement personnel, alcohol and drug abuse professionals, researchers, and industrial representatives attended this meeting.

Shortly after our last reauthorization, NIDA convened a Cocaine Prevention Discussion Group made up of experts in the field. The group felt that there was a pressing need for the dissemination of new research and epidemiological information, in understandable language, to all segments of the general public. Since then, the group has identified a number of new or revised resource materials, including books, pamphlets, films, and videotapes, and is developing a network for disseminating this knowledge through a wide range of public and private sector agencies. NIDA itself has developed a resource package to provide to individuals and groups interested in becoming involved in cocaine prevention activities.

During the past 3 years, NIDA has been involved in two major national media campaigns designed to get the most accurate and current information about drug abuse--the information which our research provides--to carefully targeted audiences. The 1983-1985 NIDA Drug Abuse Prevention Media Campaign was developed to reach parents and young people with drug abuse prevention messages through a broad range of media materials. The campaign was designed to motivate parents to learn about drugs, talk to their children about the drug problem, and join with other parents to fight drug abuse in the community. Equally important, NIDA wanted to motivate young people to take their own action to resist peer pressure to use drugs, and, accordingly, a major theme of the campaign was "Just Say No." This message was integrated into radio and television public service announcments distributed to broadcasters nationally and into print materials distributed to organizations and agencies throughout the country.

In 1985, NIDA launched Phase II of this highly successful campaign by expanding its target audiences to include minority, inner city young people, ages 10 to 14, and their families. Phase II used subway transit ads with antidrug messages and new radio and television public service announcments, featuring Black and Hispanic narrators and appropriate urban settings. In addition, the drug information flyers used in the campaign were translated into Spanish. The Phase II strategy was supplemented with a unique project, a music video aimed at teenagers, which forcefully brings across the message that you can be drug free and still successful and accepted by your peers. This "Just Say No" video has been widely aired on television and made available on free-loan for use by community groups of parents and young people. I would like to show it at the end of my statement.

NIDA will shortly be launching another major media campaign focused on cocaine. The campaign's primary audience will be young adults, 18 to 35 years old, including those working and in college. It will encourage young people and other potential users to resist the pressure to use cocaine and, will provide serious, authoritative information about the known health consequences of the drug. Families, friends, employers, and coworkers will be secondary target audiences.

Needham, Harper Worldwide, the volunteer ad agency for the recent "Just Say No" prevention campaign, will also work with the Ad Council on this project. In addition to television and radio spots, the campaign will include print ads and articles in newspapers and magazines, transit ads, information bulletins and fact sheets, posters and other collateral materials, and exhibits at meetings and conferences. A number of major corporations are working with NIDA to help mobilize corporate America to participate in the campaign. Two magazines--Fortune and Institutional Investor--have offered to assist in marketing the campaign. We believe the campaign will be successful in changing societal attitudes toward cocaine by increasing awareness of the substance as a dangerous dependence-producing drug and in changing societal attitudes toward it.

I would like now to show you the Just Say No Video. Following that, I would be happy to answer any questions you may have.

Senator **Hawkins**. The NIDA Advisory Council recently approved the addition of a new prevention line item to separate those funds currently being spent on prevention activities from the direct operations line item.

Do you support that emphasis on prevention money?

Dr. **Jaffe**. I think it would be helpful. I think that when people look at our direct operations, they do not realize that the entire epidemiological program of the United States, which supports other countries as well, is part of direct operations. They do not realize that the major media campaigns, the development of all of the general prevention efforts and the support of various parent groups that are so critical to the prevention activities are all part of our direct operations; and breaking this out as a separate line item would make that clear.

Senator **Hawkins**. Has any thought ever been given to expand the high school drug survey to include junior high school and elementary school drug abuse?

Dr. **Jaffe**. I do not know how much thought has been given to that. I can find out.

Senator **Hawkins**. Could you send out a quiz and see?

Dr. **Jaffe**. Well, to the best of my knowledge, I believe that the high school survey is based on an individual filling out a questionnaire. At some point, you can get to a level where people simply do not have the cognitive skills to fill it out for themselves.

Senator **Hawkins**. I am talking about your department and how much thought has been given inside your department to expanding it to this. We did the PAR research, a grant—that is the only one I can find. And that included junior high school.

Dr. **Jaffe**. We do get some young people down to age 12 in the National Household Survey. There were previous surveys on junior high school people and the rate of use, and there are some separate, special studies which give us some notion of the age of onset of drug use. Whether the high school survey, which is conducted by a specific investigator, can be moved downwards, I cannot answer. But I can provide that for the record at a later time.

Senator Hawkins Would you, please?

[Information supplied follows:]

The following is in response to Senator Hawkins' request for further information on junior high school drug abuse survey data.

A national survey indicating drug abuse among junior high students has been under consideration at the National Institute on Drug Abuse (NIDA) for some time because of its possible usefulness in the prevention field.

There are several reasons why such a survey has not been instituted.

- Although it would appear to be a cost-effective measure to include more subjects in our current High School Senior Survey, it is not possible. The survey is an investigator-initiated study funded under the grant mechanism, and the investigator feels the inclusion of other than seniors would compromise the cohort-sequential design of the study.
- NIDA has made efforts to stimulate a grant proposal to conduct a national junior high survey which have been unsuccessful at this point in time, however, a grant announcement is currently being prepared covering drug abuse epidemiology including surveys of younger students.
- We currently contract for a National Survey on Drug Abuse, and to add a second contract for a junior high national survey would be prohibitive under our current budgetary constraints, as opposed to an approved grant which would fit into our appropriation level.

It should be noted, however, that although we do not have a NIDA survey for younger students, we do receive important data on this age group through other mechanisms. Both our household and high school surveys provide us with age of first use data which is valuable in directing prevention efforts. In addition, there are at least 11 States which include 7th or 8th graders in their surveys of drug use. These surveys provide us with useful indicators of the types of drugs likely to be used by this age group, as well as age of first use.

Senator **Hawkins**. A copy of the "Encyclopedia of Psychoactive Drugs" entitled, "Marijuana: Its Effect on Mind and Body", written by a Ph.D., Dr. Miriam Cohen has been brought to my attention. It was authored in 1985. This book contained disturbing statements, including a photograph I will show you under which the caption is, "By the mid-1960's, marijuana had lost much of its stigma as a killer drug, and its widespread use linked American youth of all classes." Statement of fact, and picture.

They have another line in here, "A 45-day-old human embryo at a critical point in its development is very sensitive to any external agents that can cross the placenta and cause birth defects. Thus far evidence has not shown that marijuana produces birth defects."

Now, those are alarming statements, and the rest of it is like a trip out of reality. I do not know anything about the author. I am going to investigate how they got the grant.

I noted your name is listed inside the front cover, "Dr. Jerome Jaffe, M.D.", was given some of the credit inside here.

What is your affiliation with this publication? Was it federally funded, to your knowledge, and is Dr. Cohen a current Federal grantee?

Dr. **Jaffe**. To the best of my knowledge, Dr. Cohen has never been a Federal grantee. This is in no way federally funded. It was a private undertaking. I was a consultant to it long before I entered Federal service. My role was limited to suggesting authors. Dr. Cohen was not one that I suggested to the publisher.

Further, I did not see the text of this prior to its publication. I did see the text of several other volumes, which were quite good, as a matter of fact, such as the ones on tobacco and amphetamines.

I wrote to the publisher when this was brought to my attention and expressed dismay comparable to yours. Most of the difficulties were in fact in the captions, and not in the text.

Senator **Hawkins**. I do not like the pictures, either.

Dr. **Jaffe**. No; the captions of the pictures.

I was told by the publisher that the man who was responsible for inserting the pictures and the captions is no longer with the publisher. I arranged for the publisher to make contact with the key members of the parents' group and other interested parties. To the best of my knowledge, that has been done. Publication of this volume has ceased. It is now in the process of being revised with input from people who are, I believe, knowledgeable and involved in the education of young people.

Senator **Hawkins**. I will leave your statement on the record, not mine.

Peggy Mann has written a very definitive book, accepted by all as probably the latest bound volume on marijuana, the "Marijuana Alert" book. It is hard for me to believe that we are all reading out of the same hymnal and the same studies. We all know that we learned a lot after the DNA was isolated. There are some fantastic developments that prove to the best minds, that genetic defects could be passed on to the second generation through the male sperm from heavy marijuana users.

We have made a lot of progress in the last 15 years on this. I suddenly understand why it takes so long to make progress when you have to work with a bureaucratic group which loses its leader or leaders now and then, and you have to go back and give some esprit de corps to the group. But I am very disturbed by this. I think it flies in the face of everything we have been trying to prove here for the last 6 years I have been here, or 5 years—it seems like 6.

I just think we ought to say all the things that you have done. You do not want to be associated with this, but you are. Your name is on there. It was a recent publication. And I am disturbed by it and also by the false message that it sends. I was given a copy, and went through it with several parent groups in my State that are outraged by it—not alarmed, not disturbed—they are outraged by it. And I might say that we have probably just heard the beginning of that.

In your role as Director of NIDA's Addiction Research Center in Baltimore, could you expand briefly on what you consider are the important activities in intramural research?

Dr. JAFFE. Well, the intramural program is divided into three major working groups. There is a preclinical group that works on animal behavior and on the neural substrates of reinforcement. That group is looking at the environmental conditions that determine which drugs animals will self administer, and they have done some remarkable things with that. They are now beginning to focus on what environmental conditions facilitate drug cessation.

The group has also looked at which neurotransmitters may be involved in reinforcement, where in the brain cocaine may produce its specific effects, and which transmitters may be involved in drug withdrawal effects.

They are also looking at the genetic determinants of drug self-administration, with the hope that by developing models of that kind, they can look at potential interventions.

The neuroscience group is looking at receptors for drugs such as cocaine, and the effects of drugs on neural systems, particularly using modern imaging techniques to see where in the brain drugs have their effect. As a part of this effort, they have been looking at the way in which drugs may alter the structure of the brain, even with occasional rather than chronic use.

The same neuroscience group is looking at the way in which genes regulate neuronal action.

The clinical group which integrates with the neuroscience and the prelinical group is looking at about four major priorities. One, which will be instituted sometime in the next few months, is the effect of drugs on the immune system. We are interested to know to what degree certain of the commonly abused drugs may make those people who are sero-positive for AIDS more vulnerable to developing the disease

In addition, we have been instituting programs looking at the cognitive effects of drugs, to what degree various self-administered drugs interfere with thinking, memory and behavior. We have a project that has been ongoing for some time on the abuse potential of nicotine, and looking at the tobacco withdrawal syndrome.

We have within the past year instituted work on cocaine, with the objective of trying to learn more about how cocaine gains such control over behavior, the nature of the cocaine withdrawal syndrome, and what drugs could be reliably expected to alter craving for cocaine. And a last project is the effect of anxiety and anxiogenic drugs on drug-taking behavior.

Senator **Hawkins**. Thank you.

Senator Dodd, questions?

Senator **Dodd**. Just one question, if I can. It has to do with your comments on the "designer drugs". You describe them here and the dangers.

What, specifically, is NIDA doing about them? As I understand it, there is a real danger that you will get the tremendous explosion because of the totally insignificant costs of production once you have been able to put together the chemical combinations, obviously, as we know already, more potent than many of the other drugs we have acquired through other means. Of course there have been a number of deaths in the California attributed to "designer drugs".

What, specifically, is NIDA doing about it?

Dr. **Jaffe**. NIDA is doing a number of things, one of which is to work with DEA in terms of having these drugs synthesized. Once somebody finds a new "designer drug," one has to first determine what it is. Then the problem is to synthesize enough of it so that you can develop methods for detection in body fluids, to identify it, and to synthesize enough of it to carry out the studies required to determine its toxicity and its effects. With that kind of data, we can support DEA in its effort to put these drugs into the Controlled Substances Act so that they can gain a legal purview over the manufacture of those drugs.

There seems to be for the time being a gap in the law that permits people to manufacture things that are not specifically listed in the Controlled Substances Act.

Senator **Dodd**. Well, you compliment us here in that same paragraph for "having moved quickly to close the loopholes in the Controlled Substances Act, that has prohibited the manufacture and sale. . . ." I think we tried, anyway, to broaden the language significantly enough so as to from our standpoint, dealing with the particular problems that drug enforcement agencies, law enforcement agencies, generally would have in this related area.

Are you telling us that still is a problem? I am reading, by the way, from page 2 of your testimony.

Dr. **Jaffe**. To the best of my knowledge, I think the Senate has moved rapidly on that.

Senator **Dodd**. So are there still loopholes out there? Is that a problem?

Dr. **Jaffe**. I think that the bill passed the Senate; it is pending in the House.

Senator **Hawkins**. That is the problem.

Senator **Dodd**. I am sorry; you said, "the Congress has moved quickly to control the loopholes"; I presumed there you were talking about the entire place here.

Dr. **Jaffe**. I think I must be insensitive to the nuances——

Senator **Dodd**. Particularly in the Senate, I think, yes. [Laughter.]

Go ahead.

Dr. **Jaffe**. Well, the third thing that NIDA does, as it discovers the toxicity of these drugs—and it has found significant toxicity with some of them—that kind of information becomes incorporated into our various campaigns of prevention.

In some ways, the introduction of such drugs into the illicit traffic makes the illicit use of drugs far more hazardous than it already is. And to some degree, we can make use of that added hazard in our prevention efforts, to try to get people to avoid the use of illicit drugs. So they are the three things that we can do.

We welcome any further suggestions as to what we might be able to do.

Senator DODD. No, I was just curious as to how it was working, and if there is still that problem with the House of Representatives in getting legislation adopted. What is the problem? Have you talked to Members over there, the chairmen of the various committees or other people, to find out what the difficulties are?

Dr. JAFFE. I have not, sir.

Senator DODD. Well, that might be something you would do, and it seems to me that that is a major problem. If that is a loophole in the law, that no matter what you do to provide DEA with information, if they do not broaden the parameters of the legislation that would allow people who are in the production or producing these kinds of drugs to be arrested and dealt with accordingly, it seems to me we are wasting an awful lot of time.

You do not know what the problems are over there?

Dr. JAFFE. To the best of my knowledge, the lead on this belongs to DEA and FDA. NIDA's role in this is complementary. We get the toxicity data and we can synthesize the drugs, but the scheduling per se is primarily a DEA-FDA responsibility.

The Centers for Disease Control [CDC] also plays a role. A number of steps are taken when they hear that some drug is being sold that is not, if you will, a traditional drug. Then investigators make a site visit and try to analyze the substance. They then take additional necessary action.

Senator HAWKINS. In the meantime, they are purchasing a heck of a lot of it in Miami, I want to tell you. And the movie that we showed in this committee last year was produced by the State of California. I do not understand why the State of California does not bring you that movie and show it to you, and go and show it to the House. I am willing to draft a letter today, and I know the Senator will join me in sending it over to the House side and telling them to close that loophole.

They talk a lot about what they do. They love to travel to Latin America all the time and beat up on those countries. I would like to see them do something in the United States of America for a change, for our children and this generation, not the next generation.

Dr. JAFFE. I would certainly applaud those efforts, Madame Chairman.

Senator HAWKINS. And those movies are frightening, actual cases, that come from California. We have just had big headlines in all the newspapers, and I guess that is going to have to be our journal of communication, but I do not know that every druggie or kid in Florida reads those newspapers, which say, "Look out. There is an epidemic of this. It is on the streets. There is evidence that it is in Miami now, and you do not know if the next dose you buy is going to be 'designer' or synthetic or not." And there is a lot of evidence there that it is causing the palsy. We are going to have an epidemic, and you are going to really have problems, all over the United States if we do not start learning from what other people know.

I am happy to call up those fellows on the other side and tell them to get busy, and pass that legislation. But to me, there is too much evidence out there; there is so much we bring to this committee. And then everybody says, "Well, we did something about it." We talk about it. But we do not do anything about it. And I am such a fond admirer of the next witness we have, because he is a grantee He is doing all he can down there in Miami. We turned his name into the weekly magazine, and he is going to be the cover story of one of the weekly magazines next week; on developing a Family Therapy Center in Miami.

You know, we put this total burden on family; this is the family subcommittee. And I have really had it with the bureaucrat problem that we have in this city. And it is not your fault; maybe it is the very design of the agency that is supposed to help that kid on the street.

Who is going to help that kid on the street? That is what I want to know. I know that is all Senator Dodd echoes in his State and in the United States of America; there are no borders when it comes to this outbreak that we have. I would like to put all of you around one table and keep you there until we can do something that would solve the total problem, or at least make some steps toward that.

I have no further questions.

I know you have a short film, and I would like to ask you to hold it until the end of the hearing, please, as time has encroached upon us, and I am supposed to leave at 11:30.

We will excuse this panel at this time.

Thank you.

As our second panel, we are pleased to welcome Dr. Jose Szapocznik, an NIAAA grantee from the University of Miami. He directs the Family Therapy Center in Miami, and in this capacity, developed a model treatment and prevention program targeted at the entire family of the substance abuser, a dynamic program. It has had an effectiveness rate of 85 percent, and for cocaine abuse, it has been 100 percent effective—absolutely dynamite. I would like people to stay and listen to this. This is not a beginner's program. This has had an effective track record.

We welcome also Dr. Thomas Babor, a renowned alcohol abuse researcher, currently serving at the University of Connecticut Health Center. Dr. Babor has been involved with alcohol abuse research since 1971, and has recently been testing cost-effective methods of early intervention treatment for problem drinkers.

I am proud to welcome you here, Dr. Szapocznik, and look forward to hearing your testimony. I regret we did not have you up first. I could spend the whole time with you. I have got to tell you, I have had it with this agency.

Welcome.

STATEMENT OF DR. JOSE SZAPOCZNIK, RESEARCH PROFESSOR OF PSYCHIATRY AND DIRECTOR OF THE SPANISH FAMILY GUIDANCE CENTER AND THE MIAMI WORLD HEALTH ORGANIZATION COLLABORATING CENTER, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF MIAMI, CORAL GABLES, FL AND DR. THOMAS F. BABOR, ASSOCIATE PROFESSOR, UNIVERSITY OF CONNECTICUT SCHOOL OF MEDICINE, DEPARTMENT OF PSYCHIATRY, AND ASSOCIATE DIRECTOR, ALCOHOL RESEARCH CENTER

Dr. Szapocznik Thank you.

I am delighted to be here, Madame Chairman, and distinguished colleagues and guests.

At the University of Miami School of Medicine, we have been conducting research on the treatment and prevention of nonnarcotic poly-drug abusers since 1973, and have received funding from the National Institute of Drug Abuse for four major treatment research projects and one prevention research project since 1974. We have been funded for the last 12 years.

The family has always been the cornerstone of our research, because the children, adolescents and young adults whom we have targeted are always closely linked either by living arrangements, or more importantly, through emotional bonds, to their families.

Research findings in the treatment and prevention areas have repeatedly revealed that family-oriented intervention—that is, those interventions that support and promote family strength, cohesiveness, and family well-functioning—are consistently found to be among the most effective procedures for drug treatment and prevention.

While there are important moral reasons for maintaining the family as the essential building block of our social fabric, there are equally compelling theoretical and scientific reasons for using family strength in the treatment and prevention of drug abuse.

Our research has allowed us to construct detailed procedures for harnessing the family as the principal preventor and treator—that is, as the principal curative factor in drug abuse.

Our work is based on a theory called "Strategic Structural Systems Family Therapy". This approach sees members of a family as interdependent individuals who develop certain ways of interacting with each other. Our job in the treatment and prevention of drug abuse is to ensure that those ways in which families typically interact are conducive to maintaining their youth away from drugs, in the case of prevention, and are directed at removing the youth from drugs, in the case of treatment.

Our success is largely due to having developed methods for winning families—that means each and every member of the family—to our side before we attempt to do therapy. In this fashion, families do not feel alienated from the therapists, but rather become our treatment allies.

The work with these families is truly rather complex and cannot be easily explained in this brief presentation. This work has been published in numerous research and clinical articles, book chapters, and books, and some of it is reviewed in the material we have distributed earlier.

With regard to results, I would like to summarize the most important aspects of the findings of our research funded by the National Institute on Drug Abuse.

First, we have now developed a procedure for providing family therapy that has been demonstrated through rigorous research to eliminate drug abuse in youth in a remarkably short time—an average of 12 outpatient sessions—a highly cost-efficient procedure.

Second, families are not always fully available for drug abuse treatment. For that reason, we have now developed a procedure for conducting family therapy even when the whole family is not present in the therapy session.

Thus, it is no longer necessary to have the entire family present all of the time to conduct family therapy. Our modern and specialized techniques allow us to modify family interactions even by working with the drug abuser alone, thus extending the potential of family therapy to cases where the family may not be available for treatment.

What is critical here is that even when working with the drug-abusing youth alone, we must always remember that it is in the family context where we want to introduce the curative and protective factors that will keep the youth away from drugs.

The research on this new modality of treatment, which we call "one-person family therapy," reveals this technique to be remarkably powerful; it is capable of removing the problem of drug abuse in 12 outpatient sessions—again, a highly cost-efficient procedure.

Third, a very recent development in our research has been a new and revolutionary technique for engaging and maintaining in treatment those youths who traditionally refuse to come to treatment, as well as for convincing their parents of the value of family therapy. While this study is just now being completed, and the data are not yet fully analyzed, the results are tremendously encouraging.

In the first 58 cases identified as having a drug abuse problem in the youth, and who called our center for help, we were able to engage, maintain and successfully treat 85 percent of those assigned to the new experimental procedure. This 85 percent success rate compares very favorably with the 35 percent success attained in our control group.

These specialized techniques used to engage these drug-abusing youth and their families were also developed based on our strategic structural systems family therapy model. In this last study, we found that for the first 37 cases of reported cocaine abuse at admission, 100 percent of them had given up all cocaine use at the time of termination, typically within 12 sessions. Granted, longer term followups are needed to determine the long-term impact of our procedures.

Now that I have briefly reviewed the research findings of our work funded by NIDA, I would like to propose some recommendations.

First and foremost, I want to underscore in the strongest way the importance of continuing to fund meaningful applied research in the reauthorization of NIDA.

Second, I want to encourage greater emphasis on family-oriented research as the cornerstone of our prevention and treatment of youthful drug abusers. I underscore once more that family-oriented work has perhaps one of the best, if not the best, track record of success in drug abuse treatment and prevention of youthful drug abusers.

Third, I recommend that longer followups be required when conducting treatment and prevention research. The current funding structure may discourage long-term follow up.

Fourth, much is said about prevention. Typically, when discussing prevention in NIDA, most emphasis is given to risk factors, particularly in basic research. In contrast, not enough emphasis has been given to protective factors.

Fifth, I support preventive efforts that seek to mobilize communities, such as parent groups movements, and I would encourage further research in these areas.

Sixth and finally, I encourage mechanisms that will allow investigators who have proven productive and successful in the past to spend more time in productive research and less time in paperwork, applications and reapplications.

I do not need to remind you of the severity of the problem of drug abuse among our adolescents. I think, however, that our presentation to such an auspicious group would not be complete without a reminder of the human element that concerns us all.

Some examples of the cases that we have seen are: the 13-year-old pregnant, drug-abusing teenager; the 14-year-old who overdosed on cocaine at school; the 15-, 16-, and 17-year-olds, some from "good" families, who deal in drugs to support their habits, and some of whom we have literally had to rescue from life threatening situations at the hand of the ruthless drug distribution corporations, as the Senator so well called them earlier.

Because of the spread in severity of the epidemic, the service provider will not be able to work alone. The service provider's role is to harness family strength by supporting and preparing families to carry out their required work in their homes and in their communities.

Thank you.

Senator HAWKINS. Thank you, Doctor.

[Information supplied for the record follows:]

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Overview of Current Research Activities of the Spanish Family Guidance Center, Miami, Florida in the Area of the Treatment of Drug Abuse: A Report to the National Institute of Drug Abuse for Purposes of Updating the Triennial Report

September 30, 1985

APPENDICES

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G. Survey of prevalent engagement techniques available to the Miami community.

H. Structural Systems Engagement Mapping Procedure (draft)

TABLES

1. Successful Engagement by Condition (p. 13)

2. CODAP Data on Frequency of Cocaine Use by Adolescent Subjects at Intake and Termination for those Adolescent Subjects who Reported Cocaine Use at Intake

3. Levels of Engagement Effort

4. Systematic Application of Strategic Structural Systems Intervention to Focal Problems of Cocaine Abuse Treatment

Figure 1

Evolution of a Strategic Structural Systems Intervention for the Treatment of Adult Cocaine Users

Introduction

The purpose of this report is to present an overview of the current research activities of the Spanish Family Guidance Center, Miami, Florida, in the area of the treatment of drug abuse. This report will be divided into four major sections. Section 1 will describe the evolution of the Structural Strategic Systems (SSS) approach to the treatment of drug abuse at the Spanish Family Guidance Center. Section 2 will briefly review the findings of an earlier NIDA project (Grant No. 1H81 DA0259) on work in the area of developing SSS interventions for the treatment of families of drug abusing adolescents. Section 3 will briefly review the currently available findings on an ongoing NIDA project (Grant No. DA03224-05) on developing an SSS intervention for the engagement and maintenance of families of drug abusing adolescents in treatment. Section 4 will briefly review research plans that are currently underway for developing an SSS intervention modality that builds on the previous work by integrating the SSS therapeutic interventions developed in the first NIDA project with the SSS engagement and maintenance intervention developed in the second NIDA project. This currently planned research seeks to extend the use of these SSS interventions to young adult cocaine abusers. Representative publications, reports and manuals are appended and noted at the appropriate places in the report narrative.

Section 1

Evolution of Strategic Structural Systems Approach in the Treatment of Drug Abusers at the Spanish Family Guidance Center

The Spanish Family Guidance Center was established in 1972 at the University of Miami. The primary purpose of the Center is to conduct programmatic research on mental health and drug abuse treatment, including the development, demonstration and investigation of innovative treatment procedures that incorporate the drug abuser's social ecology. An early study at the Center, "Individual Ecological Therapy" (Scopetta, Szapocznik, King, Ladner, Alegre & Tillman, 1977) examined the relative effectiveness of two individual treatment modalities: ecological versus intramural individual therapy. The former was conceptualized within a systems framework while the latter focused upon therapeutic interventions occurring within the relationship between client and therapist. A second study (Scopetta et al., 1977) compared ecological family therapy vs. intramural family therapy, focusing on the family rather than on the individual drug abuser.

The results of these two studies, taken together, provided support for the efficacy of working with the adolescent drug abuser's family not only as a relevant unit in the client's ecology, but more importantly, as a system within which treatment should be conceptualized and implemented. This early research lead us to the conclusion that the conceptualization of drug abuse problems and their treatment in terms of family, ecological and structural theory is useful in maximizing treatment effectiveness with drug abusing clients. Our work since that time has focused on the development and implementation of a theoretical model for putting our clinical experience into practice, and on conducting studies to rigorously evaluate these procedures.

The model we have developed, Strategic Structural Systems (SSS) Theory (Szapocznik, Foote, Rodriguez & Blaney, in press), can be applied to a wide range of focal problems. A common ingredient in all such applications of the SSS theory is that both the problem and solution are defined by focusing on the interactions which are a normal part of the social ecology. These interactions occur in small organizations of individuals (e.g. families) as well as interactions occuring between family members and other part of their ecology (e.g. work, peers, or government). Significantly, the principles which are useful in understanding and modifying these interactions are the same within all such organizations of individuals. The different kinds of organizations are called **systems**. Because the interactions that occur within the system very often repeat and form recognizable patterns, they can be labeled to make it more convenient to discuss an individual system's patterns of interactions. The unique pattern of interactions within a system is called the system's **structure**. When it becomes necessary to bring about a change in a system, it is done by changing the patterns of interaction (the systemic structure). The plan for change is called a **strategy** and the outcome is then referred to as a strategic structural change. As stated earlier, the principles for understanding the structure of systems and the strategies for modifying structure are the same for all systems. These principles are unified within a model known as Strategic Structural Systems (SSS) Theory. This work builds on considerable prior work by system, structural and strategic writers such as Minuchin (Minuchin, 1974; Minuchin, 1976; Minuchin and Fishman, 1981), Haley (1976) and Madanes (1981). Because the key concepts of Systems, Structure, and Strategies are at the core of the interventions proposed for this project, each will be briefly discussed in greater detail next.

Systems. This is the first fundamental concept of the SSS approach. In the SSS approach, problems are identified as occurring, not in isolation, but in the context of the system in which the individual or groups (called subsystems) find themselves. These systems might be family, school, work, organizations or even whole communities. The SSS approach stresses that individuals and individual behavior can only be understood in terms of the context -- the system and subsystems to which the individuals belong.

A system's perspective dictates that behavior be viewed as both interactive and interdependent. Thus, if a system is to maintain itself, the behavior of each subsystem and even of each person must coordinate with, and be contingent upon, the behavior of others. This idea is called the **principle of complementarity** (Szapocznik et al., 1984) and implies that behavioral changes in one part of the system necessitate changes in the other parts.

Structure. The second fundamental concept of the SSS approach is that of structure. The key phrase is "patterns of interaction." Interdependent behavioral interactions tend to be repeated and thereby form, in SSS terms, a pattern of interactions. A large number of these typical patterns of behavior will evolve in any system -- a friendship dyad, a family, a work organization or a whole community. From the SSS perspective, these typical patterns of behavior -- interactions -- comprise the system's structure. Structures may be adaptive or maladaptive. When these structures or interactional patterns are maladaptive, then they give rise to symptoms such as cocaine abuse. Patients come to treatment to relieve their symptoms. In order to relieve the symptoms, the SSS therapist focuses on changing the maladaptive patterns of interaction.

Strategic. The third fundamental conceptual characteristic of the SSS approach is that it is strategic. In this case, strategic has three important and related meanings: it is pragmatic, planful, and problem focused. Pragmatic refers to the fact that whatever techniques and strategies will work most efficiently are the ones that are employed. Aside from the general activities which underlie the SSS approach (that is, joining and restructuring -- see below), there is no exclusive set of strategies that must always be used. Thus, whatever strategies that will achieve the desired structural change with maximum speed, effect and permanence can be used. This also implies that resources are concentrated on those interventions which will have maximum impact and where the system is least able to bring about constructive change on its own.

Planful refers to the fact that events are not simply allowed to happen and evolve as they will. Instead, in the SSS approach, both overall strategies and individual tactics are deliberately planned for these to have maximum impact.

Problem focused refers to the fact that, although SSS has a systems structural orientation, and therefore focuses on process rather than content, the emphasis of the process is on achieving structural changes that directly target a focal problem, in this case drug abuse. If structural changes outside the immediate context of the target problem are made, they are implemented only to the extent that they are necessary for successfully resolving the focal problem -- drug abuse. All these three features of strategic work are intended to contribute to the effectiveness and brevity of the intervention.

At this point it might be helpful to summarize these basic concepts of systems, structure and strategic.

The term system pertains to the organization as a whole and to the interactive interdependency of its parts. It implies nothing about the mode of intervention used within that system, or about how much of the system an intervention is intended to directly impact. Structure refers to the patterns of interactions that make up the system. This concept provides us with a framework for understanding interactions and for conceptualizing an intervention in terms of strategies that modify maladaptive structures and interactive patterns. Strategic pertains to focusing on the recurring patterns of interactions within the system. It leads to interventions that seek to change directly those interactional patterns that are primarily responsible for the problems presented; in this case, drug abuse.

Research using the Strategic Structural Systems (SSS) Approach. Both of the studies (Brief Strategic Family Therapy Project: NIDA Grant No. 1H81 DA02059 and Structural Systems Engagement Project: NIDA Grant No. DA 03224-05) to be described in the next two sections are family-oriented interventions targetted at substance abuse in youths. Both of these projects were developed within the SSS approach. Although Structural

Systems engagement and Brief Strategic Family Therapy were developed to address different problems (i.e., engagement versus treatment), they share in common the aim of bringing about planful, problem focused structural change in those systems that most directly impact upon the behavior of the individual drug abuser.

The major SSS techniques for bringing about change fall into two major categories: joining and restructuring. These techniques have been described more fully elsewhere (cf. Szapocznik, Kurtines, Foote & Perez-Vidal, 1983; Appendix C) and will only be briefly discussed here. In "joining," the therapist blends with the system in order to be in a position to eventually change maladaptive patterns of interactions. "Restructuring" refers to the actual change-producing strategies that the therapist uses in promoting new, more adaptive interactional patterns. Both of these techniques are central to the research projects described next.

Section 2

The Brief Strategic Family Therapy Project
(NIDA Grant No. 1H81 DA02059)

The purpose of the BSFT project was to investigate some underlying theoretical assumptions regarding current family therapy practices. Current family therapy approaches tend to share a common strategy, that is, a therapist works with the family in order to bring about changes in both the family and the family member identified as the patient. This approach is based on three assumptions: the first is that psychopathology in the Identified Patient (IP) is a symptom of and is maintained by dysfunctions in the family; the second is that to bring about lasting improvement in the IP's psychopathology, changes have to be made in the family as well as the IP, and the third is that to induce change in the family, the family must be physically present in therapy. The first and second assumptions are crucial to any family therapy approach. A major goal of this project was to examine whether or not the third assumption (that is, having the family present in therapy) is necessary to bring about therapeutic changes in the family and in the individual. Therefore, one purpose of the study was to develop and refine a therapy modality directed at changing an entire family system while working primarily with and through one family member.

In order to examine the effectiveness of working primarily with one person in bringing about family change, a therapy--outcome study was conducted comparing the relative effectiveness of conjoint family therapy with a "one person" family therapy modality. The working hypothesis of this study was that it would be possible to achieve the goals of family therapy--structural family change and symptom reduction--by working primarily through one person. The BSFT project thus attempted to bridge the "wisdom of the field" in terms of the benefits of family treatment with the reality of the inaccessibility to treatment of entire families. More specifically, the one-person family therapy used in the BSFT project attempted to treat those family-system interactions that affect and/or involve the identified patient without having the family present in all therapy sessions. One Person Family Therapy is thus an intervention modality designed to offer the advantage of system-wide impact in families in which the entire family is unavailable or unwilling to take part in family therapy.

Brief Strategic Family Therapy Project Research Findings.

The effectiveness of Brief Strategic Family Therapy was experimentally tested by assigning client families to one of two treatment conditions: Conjoint Family Therapy or One Person Family Therapy. Client-families in both conditions were extensively tested at intake, termination, and a six-month follow-up. The results indicate that overall, One Person Family Therapy was as effective as Conjoint Family Therapy in bringing about improvement at time of termination. This was true for both family functioning and symptom reduction in the IP as measured by all clinical scales. The follow-up analyses provided further evidence for the continued efficacy of both modalities on family functioning and slightly greater efficacy of the one person modality in bringing about continued symptom reduction in the IP in several areas of functioning. Thus, the assumption that family functioning can be changed while doing therapy without the entire family present was supported. The results of this project have been reported in extensive detail and representative publications can be found in Appendices A, B, C, D and E.

Section 3

Structural Systems Engagement Project (NIDA Grant No. DA03224-05).

Structural Systems Engagement was designed to address problems encountered in engaging drug abusers into treatment. One of the most persistent problems of drug abuse treatment, including family-oriented modalities, is that of engaging drug abusers in treatment. Our own data from the Brief Strategic Family Therapy project indicated that a substantial proportion of clients were lost to treatment even before the first treatment session. Out of approximately 2000 initial contacts received by the Center for this project, only 250 client-families actually came in for a screening interview. Of this number, only 145 actually completed the intake procedure. Our data suggests that a very large proportion of client-families who initially seek treatment do not engage in therapy. As noted in the introduction, the problem of engaging drug abusers into treatment is not unique to our Center. It is a pervasive one in the area of drug abuse service delivery.

The Structural Systems Engagement procedure was designed to provide an effective mechanism for engaging clients into treatment (see Structural Systems Engagement Manual; Appendix F). Like Brief Strategic Family Therapy, Structural Systems Engagement is based on the SSS approach. The Structural Systems Engagement approach builds on the same structural concepts of joining, tracking, and restructuring to achieve sufficient change in the family to obtain the collaboration of the drug abuser and other previously resistant family members. Because this research is currently ongoing, a more detailed review of the findings of the project are presented below.

The Structural Systems Engagement approach is based on the following premises: (1) the family is a self-regulatory system; (2) the symptom is a mechanism for self-regulation; and (3) the concept of systemic resistance to change results from the preceeding two. Consequently, the very same principles that apply to the understanding of family functioning and treatment, also apply to the understanding and treatment of the family's resistance to change. Through the Structural Systems Engagement model, resistance has been redefined in interactional terms. Thus, overcoming resistance to treatment is achieved by restructuring interactional patterns around the immediate problem of resistance. From this perspective, initial resistance becomes an integral part of the therapist's responsibility in treatment. **This approach differs drastically from mainstream mental health and drug abuse treatment philosophies in which patients are left with the entire responsibility for bringing themselves into treatment. In the Structural Systems Engagement model, the therapist becomes actively involved in the engagement process.**

Structural Systems Engagement is a planned, purposeful way of diagnosing, joining and quickly restructuring a family from the initial contact to the first therapy interview. It utilizes the same diagnostic, joining and restructuring skills of Brief Strategic Family Therapy but focuses on identifying and obviating the family's systemic resistances to engaging in a therapeutic contract. Thus, strategic structural systems concepts are applied not only to the issue of what to do with the family once they are in treatment, but rather, to the issue of what to do with a family in order to get them into treatment.

The goal of the therapist is to engage the family into therapy by first joining them in a way which does not initially challenge the family structure. During the process, the therapist identifies the family's hierarchical structure and makes whatever structural changes are necessary to bring the entire family to therapy.

Structural Systems Engagement Project Research Findings

In our work we have identified four general structural organizations of families of drug abusing adolescents who present engagement resistance to the therapist. These four patterns are discussed below as well as the strategies the therapist uses in dealing with these resistances.

1. Powerful Identified Patient. These families have within their structure a powerful Identified Patient (IP) and parents who are hierarchically positioned at a lower level of power relative to the IP. The salient characteristic of parental power at the initial stages of engagement is the ability of the parents to bring the child to therapy without lying to the youth. Very often, the mother of a powerful IP will admit that she is weak or ineffective and will say that her son or daughter flatly refuses to come. We can assume that the IP resists therapy because:

    1. It threatens his position of power and moves him to a "problem-person" position.

    2. It is the parent's agenda to come to therapy and thus if followed will enhance the parent's power.

Restructuring needs to be done to alter the existing hierarchical organization in which the IP is in power, thereby eliminating the resistance to initial engagement. In these cases, the hierarchical organization is altered not by "demoting" the IP (that move would be totally rejected at first) but rather by the therapist allying to the "ruling structure." The therapist shows respect and concern for the IP but also brings an agenda of change that will then, by virtue of the alliance, be shared by the IP.

In order to bring these families into treatment, the IP's hierarchical position is not directly challenged, but tracked and allied to the therapist so that the therapist may interject his formulation and solution to the problem. Therefore, the therapist initially forms an alliance with the powerful IP in order to reframe the need for therapy in a manner that strengthens the IP in a positive way. The reframing is done so that the symptom is transferred from the IP to the family (further supporting the IP's power, to be later challenged in therapy). The other alternative, that of forming an alliance with the parents, would be premature and ineffective at the early state of the engagement process. The parental sub-system is not strong enough at this point. The pressure to perform while the therapist has no direct access to the IP would render the parents even weaker and neither the family or the IP would show up for treatment.

2. Contact person protects structure. These families are

defined by a structure in which the person making the agency contact (usually the mother) is also the person overprotecting the resistant behavior. How the IP-hood is maintained in the family is also how therapy is resisted. The mother gives a double-message to the therapist, "I want to take my family to therapy but my son can't come because he forgot and fell asleep and my husband has so much work he can't take any time to come to therapy." The mother is expressing a desire for the therapist's help while at the same time protecting and allying with the family's resistance to be involved in solving the problem. Mother "protects" this resistance by agreeing that the excuses for non-involvement in change are valid. In other words, she is supporting the arguments used for maintaining the status quo. It is worthwhile to note that ordinarily this is the same double-bind in the family that perpetuates the symptomatic structure: someone complains of the problem behavior yet supports the maintenance of the problem. This pattern is typical of the family whose patterns of resistance are closely tied to a problem of enmeshment between mother and IP.

In order to bring these families into treatment, the therapist must first form an alliance with the mother by acknowledging her frustration in wanting to get help, and not getting any cooperation from the family member(s). Through this alliance, the therapist tracks the structure and thus moves to the other member and distances them from the mother. This is accomplished by exacerbating conflicts that exist between the two. Once the therapist has a relationship with this member s/he can challenge the resistance reframing the need for therapy in terms that are acceptable to the resistant member(s).

3. Disengaged parents. These family structures are characterized by little or no cohesiveness or alliance between the parents as a subsystem. In addition, one of the parents (usually the father) refuses to go to therapy. This is typically a parent who has remained disengaged from the problematic behavior. This additional resistance serves to disengage him from another problematic relationship: the other spouse. Typically, the mother is over-involved (enmeshed) with the IP and either incompetent in parenting or supporting the IP-hood in a covert fashion. For example, if the father moves in to control the behavior, she complains he's too tough or creates mythical fears about the father's potential violence. Thus, father is rendered useless and again moves out, re-establishing the disengagement between husband and wife. In this family, the dimension of resonance is of foremost importance in planning change to bring them to therapy. Mother must be brought closer to the father in tasks that distance her from the son. Very briefly, resonance is that measure of closeness/distance which qualifies any relationship. The closer (enmeshed) the higher the degree of sensitivity for one another, and vice versa, distance decreases one another's awareness of the other.

In order to engage these families, the therapist must form an alliance with the caller (usually the mother). The therapist then begins to direct the mother's interactions with the father, changing their patterns of interaction around the presenting problem so as to bring him into therapy. Mother is given tasks by the therapist to do with the father around and only around the issue of taking care of their son's problems. This is done because it must be assumed that if father and mother have become distanced there must be a degree of intensity in their issues or conflicts that necessitate that the therapist insures the insulation until they are ready to confront them. These tasks restructure their interaction in a way that stimulates his coming to therapy.

Although the pattern is similar to that in type 2, in this instance the resistance emerges differently, i.e., in this case mother does not excuse the father's distance but, quite the contrary, she complains about her spouse's disinterest. In this case, the mother is usually more willing to do something, given some direction.

4. Therapy as an exposé. Sometimes therapy is threatening to one or more individuals. They resist coming because they are afraid of being made a scapegoat or that dangerous secrets will be revealed. These individuals' beliefs or "frames" about therapy are usually an extension of the "frame" within which the family is functioning.

The therapist must reframe the idea or goal of therapy in a way that eliminates its negative consequences and replaces them for positive aims. This must be done for the member(s) of the family who is/are being victimized or threatened by therapy.

In Summary, in reviewing these patterns, it is evident that considerably more changes are needed to render a family motivated for therapy in some types than in others. For example, families in type 3 require more directions and tasks set up with the mother than in families in type 2. In turn, families in type 2 need more work than those in type 4 where a simple reframing from a position of close therapeutic alliance will do the job. Therefore, the notion of degree of change needed by different types of resistant families becomes a highly relevant issue, though not unlike the already accepted reality that some families in therapy need more thorough and deeper restructuring than others.

In addition to the work we have done on identifying types of resistant families, we also have some preliminary outcome results from the project. The project is currently being conducted at the Center and complete outcome results are not available. The outcome effectiveness of Structural Systems Engagement is being evaluated using an experimental design in which client families who contact the Center are assigned to one of two conditions: Structural Systems Engagement and Engagement-As-Usual. The Engagement-As-Usual condition is the control condition. In this condition, the clients are approached in a way that resembles as closely as possible the kinds of engagement that usually take place in outpatient centers. In the Structural Systems Engagement condition, on the other hand, client-families are engaged using techniques developed specifically for use with the types of families that resist therapy such as those described in the previous section. Although complete data are not currently available, preliminary results are reported next.

The results reported here are based upon a sample of cases closed as of March 31, 1985, in which the first contact was made before February 1, 1985 (Structural Systems engagement = 29, Engagement-as-Usual = 29, total = 58). (As of August 14, 1985, an additional 46 cases had been added to the sample, some of which are still active. Thus, a total of 104 families had met inclusion criteria and had been included in the study as of August 14, 1985).

(1) Description of Subject Population. The subject population was comprised of families of adolescents who were suspected of, or observed, using illicit drugs. The adolescents (identified patient or I.P.) ranged in age from 13 to 21 with 76 percent falling between the ages of 14 to 17 years. Sixty-seven percent were males. All families were Hispanic, with 85 percent of Cuban origin. This proportion is consistent with the composition of the Hispanic population of Dade County. The sample of parents included new immigrants as well as long-standing residents (years in U.S.A.: mean = 16.7, range = 2-41). Families had resided in Dade County for a mean of 13 years.

Sixty-four percent of the families were two-parent households. The mean head-of-household education was 10th grade (mean = 9.9). The families included a broad range of socioeconomic backgrounds, although over 15 percent were unemployed.

In most cases, the mother (85 % of first contacts) was the family member who first called the Center. During the initial contact, the therapist asked the caller to describe the I.P.'s behavior and to explain what led her to call the Center. This information was organized within the following categories: (1) actual evidence of drug use, (2) drug abuse syndrome (3) reasons caller fears drug use.

Over half (55.2%) of the callers had observed behaviors which caused them to fear that their child was using drugs. An additional one-third (43%) of the callers had direct knowledge of their son or daughter's drug use. A requisite condition for inclusion in the study was either direct knowledge of drug abuse, or four or more behaviors from the Drug Abuse Syndrome list.

Marijuana/hashish was by far the substance of choice (81%) for the subject population. Cocaine was indicated as the preferred second drug (83%) for subjects who used a second drug. The frequency of primary drug use most often given by subjects was several times per week (47.6%). Thirty-eight percent of the subjects restricted their primary drug use to one time per week or less. It is important to note that 67% of the subjects were using an additional drug conjointly with the primary drug, usually cocaine, several times a month.

Findings To Date. In sixty-two percent of the cases, the I.P. resisted coming to intake. In another 16 percent of the cases, both the I.P. and the father together resisted, and in an additional ten percent of the cases, the father alone resisted. Thus, fathers and I.P.'s together accounted for resistance to therapy in 88 percent of the cases.

Was their resistance strong enough to keep these families from coming to therapy, and if so, was the Structural Systems engagement technique capable of overcoming their resistance? In the Engagement-as-Usual condition, during all contacts, the therapist was understanding and sympathetic, but did not go beyond the minimal level of contact allowed by the protocol (Level 1). In contrast, **during the first contact with families assigned to the Structural Systems engagement condition, the therapist found it necessary to move to a higher level of engagement** in thirty-eight percent of the cases. By the second contact, eighty-six percent of the Structural Systems engagement cases were at a higher level of engagement. Thus, as established by the protocol, a higher level of engagement existed in the Structural Systems engagement condition than in the Engagement-as-Usual condition. Comparisons were made to ensure that engagement outcome was the result of engagement level and not number of contacts between client and therapist. Analysis of variance revealed that there was no significant difference in the number of contacts between the therapist and the families in the two conditions (F = 1.74; Df = 1,57; p= .19). Thus, the number of contacts were maintained constant across conditions, and only level of engagement was systematically varied.

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The results of the sustained higher level of engagement in the Structural System Engagement (SSE) condition were dramatic (Table 1). Almost half (48.3 percent) of the families in the Engagement-as-Usual condition failed to come to the Center for intake. In contrast, only one family (3.4 percent) in the Structural Systems engagement condition was lost (Chi Square = 12.95; df = 1; p = .0003).

****

Table 1

SUCCESSFUL ENGAGEMENT BY CONDITION

Count Row Pct Col Pct Tot Pct	EAU	SSE	Row Total
Not engaged	14 93.3 48.3 24.1	1 6.7 3.4 1.7	15 25.9
Engaged	15 34.9 51.7 25.9	28 65.1 96.6 48.3	43 74.1
Column Total	29 50.0	29 50.0	58 100.0

Chi Square X^2 (1) = 12.95, p = .0003

It had been a concern of the Investigators when designing the study that if Structural Systems engagement was more effective in engaging clients, but more clients in Structural Systems engagement dropped during therapy, then Structural Systems engagement would have little overall value. For this reason, in addition to the experimental engagement manipulation, clients were provided therapy and termination status by condition was assessed.

Following intake, an almost equivalent number of cases dropped out of therapy in the two conditions (Engagement-as-Usual = 5, Structural Systems engagement = 4). In the Engagement-as-Usual condition, the five cases represented 33 percent of the cases that were engaged, while the four dropped cases in the Structural Systems engagement condition represented only 14 percent of the engaged cases. **Thus, of the 29 cases in each condition, 35 percent were successfully terminated in the Engagement-as-Usual condition and 83 percent in the Structural Systems engagement condition (Chi Square = 17.14, df = 2, p = .0002).**

In addition to the findings that Structural Systems engagement techniques were highly effective in engaging client/-families, we also have some preliminary data on the effectiveness of the Brief Strategic Family Therapy modality as a treatment intervention with adolescents who use cocaine. Table 2 presents CODAP data on frequency of cocaine use for adolescents who reported cocaine use. Data are presented at the time of admission and at termination following BSFT treatment. As can be seen from Table 2, all clients reported no use of cocaine at the time of termination. These findings are extremely robust and argue for the effectiveness of BSFT as a treatment for cocaine abuse.

Table 2

CODAP Data on Frequency of Cocaine Use by Adolescent Subjects at Intake and Termination for those Adolescent Subjects who Reported Cocaine Use at Intake.

	Intake	Termination
None Last Month	0	37
Less Than Once Per Week	18	0
Once Per Week	14	0
Several Times Per Week	5	0
Once Per Day	0	0

n = 37; includes subjects terminated through August 28, 1985.

Section 4

Planned Research: Combining the Brief Strategic Family Therapy and Structural Systems Engagement Projects.

On the basis of our previous work, we have developed a conceptualization of Brief Strategic Family Therapy and Structural Systems engagement that integrates both components into a single intervention modality, the Strategic Structural Systems intervention [Condition 1 (engagement, maintenance and therapy)]. From our experience, we have found that when Structural Systems engagement is used in combination with Brief Strategic Family Therapy it is frequently necessary to continue to use Structural Systems engagement techniques to re-engage from time to time, i.e., maintain the client/families in therapy. Because many of the client/families who are engaged through the use of Structural Systems engagement techniques are client/families who are more resistant to therapy, they also tend to be more difficult to keep engaged in treatment. In treating these client/-families we have found that the types of interventions necessary to retain and/or re-engage client/families include interventions that go beyond what can be handled directly in the therapist's office. In the case of drug abusers in particular we have found that it is sometimes necessary to include during the course of therapy ecological interventions and the use of direct interventions with extended families and other systems, which may take place in the field (as compared to the office). Thus, for many of the clients engaged using Structural Systems engagement to remain in treatment, these same engagement techniques have to be used in an integrated fashion throughout the entire intervention process and frequently involve field interventions that go beyond the usual office therapy interventions.

For the past five years the staff of the Spanish Family Guidance Center has been piloting and refining the use of the Strategic Structural Systems intervention with young adult cocaine users and their families and/or significant others that combines both Structural Systems engagement/maintenance techniques and Brief Strategic Family Therapy techniques.

In this section we will describe the Strategic Structural Systems intervention as we have developed it for use in our planned research with young adult cocaine users. Strategic Structural Systems theory, as noted earlier, is a structural systems approach to intervention that targets those social ecological systems that most directly affect the behavior of the drug abuser. The Strategic Structural Systems intervention uses joining and restructuring techniques to bring about structural changes (i.e., change in patterns of interaction) in the client's immediate social ecology that support and maintain drug abusing behaviors. In our work with adolescent drug abusers, because of their age, the family of origin was most frequently the most significant social system to be engaged in the treatment process. In our work with young adult cocaine users we have found that the family is still frequently the most important social system that has to be engaged in treatment, although family has been redefined to include new families as well as families of origin. We have also found that, depending upon the client's status, it is sometimes necessary to engage significant others into the treatment process. Our preliminary work on developing a Strategic Structural Systems intervention for use with young adults indicates that we can anticipate three types of clients: (1) clients living with or significantly involved with their family of origin, (2) clients with new families (spouse and/or children), and (3) clients who are transitional but involved with a significant other (boyfriend, girlfriend, live in, etc.). Regardless of the type of system or subsystem to be engaged, however, the techniques used to engage and treat the client/families remain the same, i.e., joining and restructuring.

As noted earlier, in our work with Structural Systems Engagement, we have conceptualized Structural Systems Engagement as an extension of Brief Strategic Family Therapy. Structural Systems Engagement techniques are designed to extend the Brief Strategic Family Therapy techniques of joining and restructuring to the process of engaging and maintaining clients in treatment. Structural Systems engagement techniques are thus similar to Brief Strategic Family Therapy techniques (i.e., joining and restructuring) but they differ in the focal problem at which they are aimed. For Structural Systems engagement the focal problem is resistance and for Brief Strategic Family Therapy the focal problem is drug abuse. Structural Systems engagement techniques thus involve the application of structural systems intervention (joining and restructuring) to the problem of client/family resistance to therapy. Brief Strategic Family Therapy therapy techniques, ~~in~~ contrast, involve the application of structural systems intervention (joining and restructuring) to the problem of client drug abuse and the patterns of interaction that maintain it. Although these techniques can be considered discrete processes for purposes of explanation and analyses, in actual practice we have found that they are most effective when they are applied in an integrated fashion throughout the intervention process. Thus, during the initial phases of contact the therapist using the Strategic Structural Systems intervention first focuses on the problem of resistance in order to get the client/family into treatment and then shifts the focus to the problem of drug abuse (or other relevant systemic dysfunction) once the client/family begins treatment. However, as noted above, we have found that cocaine abusers are difficult to maintain in treatment and in order to effectively maintain the client/family engaged in therapy it may be necessary to shift the focus back to the problem of resistance to re-engage the client/family and continue therapy from time to time.

Structural Systems Engagement and Maintenance Techniques

Levels of Engagement Activity. In Section 3 we described the conceptual framework used in developing the Structural Systems Engagement techniques. Because the Strategic Structural Systems intervention used in this planned study will involve the integrated use of Structural Systems Engagement techniques throughout the intervention process, we will describe more fully the range of levels of engagement the therapist will have available during the course of intervention.

In developing the Strategic Structural Systems intervention, we have identified five levels of engagement effort. Table 3 presents the levels of engagement effort. In order to explain the levels, we have to first make a distinction between Engagement-As-Usual and Structural Systems Engagement. Engagement-as-Usual (Levels 0 & 1) are those activities that parallel the engagement activities that usually take place in outpatient centers. The method and procedures that we have used in defining these levels are described more fully in Appendix G. The types of engagement activities that occur at these levels of engagement are:

Level 0 Expressing polite concern; scheduling of intake appointment; establishing that case fits intake criteria; identifying caller; making clear who must attend intake.

Level 1 Minimal joining; encouraging caller to involve family; inquiring about depth and breadth of client's problems; inquiring about what family members exist.

Structural Systems Engagement activities (Levels 2 - 5) involve more active engagement efforts on the part of the therapists. Whereas in most therapies resistance to therapy is handled directly when (and if) the client/family enters therapy, in Structural Systems engagement the problem of resistance is targetted from the initial contact. In other words, resistance rather than drug abuse is targetted as the initial focal problem, with drug abuse becoming the focal problem only after the client/family enters therapy.

At this point, it is necessary to make a further distinction between levels of Structural Systems engagement. Structural Systems engagement levels 2, 3 and 4 represent the type of joining and restructuring activities that make up the core of the Brief Strategic Family Therapy intervention process once clients are engaged. The Brief Structural Family Therapy treatment intervention that will be used once the clients are engaged are described more fully in the next section. In Brief Strategic Family Therapy, these techniques are used after client/families are engaged in therapy. Thus, one important difference between the Strategic Structural Systems intervention and Brief Strategic Family Therapy, is that in the Strategic Structural Systems intervention, joining and restructuring techniques are explicitly extended to the initial phases of engagement. The Strategic Structural Systems intervention thus differs from Brief Strategic Family Therapy in that joining and restructuring techniques are used to get the client/family engaged in therapy, as well as after client/families enter therapy. The types of engagement activities that occur at these levels are:

Level 2 activities include more thorough joining; inquiring about family interactions; inquiring about problems, values, interests of different family members; supporting the caller and establishing an alliance with caller; beginning to establish leadership; asking if all family members are willing to keep intake appointment.

Level 3 activities include restructuring for engagement through caller; advising caller regarding negotiating, reframing, tracking in order to have family members keep intake appointment (either over the phone or personally with caller at therapist's office).

TABLE 3
LEVELS OF ENGAGEMENT EFFORT

	Engagement-as-Usual and Structural Systems engagement
LEVEL 0	Expressing polite concern; scheduling of intake appointment; establishing that case fits intake criteria; identifying caller; making clear who must attend intake.
LEVEL 1	Minimal joining; encouraging caller to involve family; inquiring about depth and breadth of client's problems; inquiring about what family members exist.
	Structural Systems engagement only
LEVEL 2	**More thorough joining; inquiring about family interactions; inquiring about problems, values, interests of different family members; supporting the caller and establishing an alliance with caller; beginning to establish leadership; asking if all family members are willing to keep intake appointment.**
LEVEL 3	**Restructuring for engagement through caller; advising caller regarding negotiating, reframing, tracking in order to have family members keep intake appointment (either over the phone or personally with caller at therapist's office).**
LEVEL 4	**Lower Level Ecological Engagement Interventions; joining family members or doing intrapersonal restructuring (with family members other than original caller) over the phone or in the therapist's office; telephoning significant others for purposes of gathering more information only.**
LEVEL 5	**Higher Level Ecological Interventions; out of office visits to family members or significant others; using significant others to help in doing restructuring.**

Level 4 activities include Lower Level Ecological Engagement Interventions; joining family members or doing intrapersonal restructuring (with family members other than original caller) over the phone or in the therapist's office; telephoning significant others for purposes of gathering more information only.

In addition to extending joining and restructuring activities to the initial phases of engagement, the Strategic Structural Systems intervention engagement activities also include activities that are unique to this modality. Level 5 engagement activities include ecological interventions that are targetted at direct interventions in the client's social ecology that involve field interventions. Thus, unlike Brief Strategic Family Therapy (and most other psychosocial interventions), the Strategic Structural Systems intervention requires that the therapist make direct field interventions in cases where such interventions are necessary to engage client/families during the initial phases of engagement and where necessary to maintain and re-engage client/-families after they enter therapy. The types of engagement activities that occur at this level are:

Level 5 activities include higher level ecological interventions; out of office visits to family members or significant others; using significant others to help in doing restructuring.

Engagement Mapping. In addition to the levels of Structural Systems engagement techniques that we developed as part of our previous work, we have also developed some new techniques to facilitate the use of Structural Systems Engagement with young adults. In our work with adolescents, the most relevant system in the adolescents' social ecology was the family of origin. Because the social ecology of the young adult is more variable and can include new families and significant others as well as the family of origin, we have developed a procedure called "Engagement Mapping" to enable the therapist to quickly identify the relevant social ecology.

Engagement Mapping provides a method for identifying systemic structures that contribute to the focal problem of resistance. Engagement mapping is done as early as possible so that the therapist is ready to move if needed. In the previous SSE project (see Section 3), this was done clinically in a non-standardized fashion. The clinical maps were used to identify the four types of resistant families described in the Section 3. In this study, we will use the standardized engagement mapping procedure described in Appendix H to identify the types of resistance characteristics of young adult cocaine abusers. It should be noted that the mapping procedure used during the engagement phase is similar to the mapping that is done in Brief Strategic Family Therapy during therapy. During therapy, mapping is used to identify structural relations impacting on drug abuse in order to know what types of changes to eliminate drug abuse. During engagement, mapping is used to identify structural relations impacting on resistance to therapy in order to know what types of changes to make to overcome resistance. The use of mapping during both engagement and therapy is thus part of what we have earlier referred to as being strategic and planful. Mapping provides a strategic and systematic method for identifying structures that maintain any type of focal problem. In this case the focal problem is resistance to entering therapy. The Engagement Mapping procedure is described more fully in Appendix H.

Brief Strategic Family Therapy Treatment Techniques

Once client/families are engaged in therapy, the focal problem will shift from resistance to drug abuse (or other relevant problems related to drug abusing behaviors) and the therapist will use Brief Strategic Family Therapy treatment techniques. The Brief Strategic Family Therapy techniques that will be used in treatment are briefly summarized in this section.

The focus of this discussion will be on how Brief Strategic Family Therapy techniques will be used with young adults in the planned research. The techniques that will be used fall into the two categories of joining techniques and restructuring techniques that characterize structural family therapy. In our work at the Center, we have further developed these techniques for use either in the conjoint modality (with the entire family system present) or in the one person modality (with only one person from the family system present). For research purposes, in our previous work we have refined the use of the conjoint and one person techniques separately. However, in actual practice we have found the techniques to be more effective when applied in an integrated fashion and used to suit the needs of individual client/families. Thus, although we will discuss these techniques separately for purposes of explanation, in actual practice, both types of techniques will be used depending upon the particular situation of each client/family.

For example, in cases of young adults living with or closely identified with the family of origin, the therapists can be expected to utilize conjoint techniques as necessary to make the necessary structural interventions in the family of origin. In cases involving clients with new families, the therapists can also be expected to use conjoint techniques as necessary to make structural interventions. In cases of transitional young adults, the therapists can be expected to use mainly one person techniques (i.e., work mainly with the identified patient) to make necessary structural interventions in the client's social ecology. Thus, although the techniques described next will be discussed separately, therapists will be free to utilize both types of techniques as appropriate with the type of situation that applies to each client/family.

Conjoint Techniques.

The joining and restructuring techniques described in this section will be used when the identified patient either lives with the family of origin or has a new family of his/her own. Whenever possible, these techniques will be used in sessions involving the entire family or as many sub-systems as are available for therapy.

Joining. The creation of a therapeutic system is an essential preamble to creating change within a family. it is through joining that the therapist can experience and thus diagnose the family's interactions. In joining it is essential that the therapist accept the family organization as is, thus eliminating the possibility of perceiving an artificial system or of alienating the family. The therapist joins by initially supporting the family structure, by tracking its patterns of communication (i.e., initially following the content and patterns of communication set up by the family), and by mimesis of the family's style, affect, activity and mood. The above techniques help the family to be at ease, and provide the context within which the family can enact the dysfunctional behavior patterns which bring them to therapy. Enactment refers to encouraging or facilitating the family to behave/interact in its characteristic fashion. In order to encourage enactment, the therapist systematically redirects communication to encourage interaction between family members rather than family-therapist interaction. It is also through joining that the family makes a commitment to the new system, thus minimizing the chances of dropping-out or resisting change. Finally, it is in the process of joining that the therapist establishes her/himself as a leader, a position which facilitates restructuring interventions by making the family amenable to the therapist's therapeutic manipulations.

Restructuring. Once a therapeutic system is established, and once the family has been permitted to operate in its usual fashion, the therapist is now ready to restructure by promoting, facilitating, suggesting, and actually directing alternate organizations, structural arrangements, and interactional patterns. It is here that the therapist challenges the familial status quo, tests its flexibility for change, and creates situations which permit more functional alternatives to emerge. There are a variety of ways in which change-producing interventions can be made. Often these techniques enable the therapist to shift alliances or change boundaries within the family system. For example, dysfunctional communication patterns can be blocked by the therapist while new interactions are prescribed. Also, restructuring need not necessarily be aimed at the whole system, but oftentimes involves only subsystems within the family. While restructuring, it is important to continue joining activities. In particular the therapist needs to apply supportive techniques in order to prevent the family from being overly stressed. Thus, even though it is sometimes necessary to create stressful crisis situations, there are times when the therapist applies supportive techniques to keep the stress within a tolerable range and to maintain the family in treatment.

A number of techniques can be used to restructure and shift family interactional patterns. Some examples are:

1) Reframing - the therapist relabels a process, a person, or an event. An alternative organization, label, or even essence is offered for the entity. This new conceptualization implies a new way of behaving towards that entity.

2) Reversals - the therapist changes a habitual pattern of interacting by coaching one member of the family to say or do the opposite of her/his usual response. A reversal of the established sequence breaks up previously rigid patterns that are pathological, and allows new alternatives to emerge.

3) Detriangulation - here the goal is to shift the motion of a triangle since triangulation prevents dyadic relationships from processing and growth. Detriangulation permits the dyad in conflict to transact "business" or feelings directly. Detriangulation also frees the third party from being used as the repository of the system's dysfunctions. For example, in a family where there is a close alliance between mother and son, as well as a strong marital conflict, the father frequently gets at mother through the son by denigrating and belittling him. It may be that the son and mother actually pair up to keep the father distant from the family. When father wants to get to mother, he can do so by placing his son in an IP role. Detriangulation of the son may be achieved by breaking up the alliance between mother and son. This may be done by having the son participate with father in activities together such as sports. Actual detriangulation can now be accomplished by coaching the son to set boundaries between himself and the parental couple, particularly when conflict emerges between the parents. This can be accomplished by having the son leave the scene of an argument. Thus, now, when the father wants to get to mother, he will have to do so more directly.

4) Opening-up Closed Systems - closed, dormant systems give the appearance of calm so that the tension can be felt somewhere else in the family. One way to open such a system and thus realistically confront the problem-genesis is to activate it by creating crises, thereby, magnifying small emotional issues. This in turn activates dormant interactions so they can be dealt with openly and in a new manner.

5) Tasks - the new interactions fostered in therapy

sessions by the techniques described above are strengthened by the assignment of tasks. An essential aspect of conjoint techniques is that in order to promote generalization of the new patterns emerging during therapy, the family is given homework tasks which repeat in the natural context the in-therapy experience. Thus, various family members are directed to carry out certain interactions at home, after these interactions have been successfully carried out in a therapy session. The task must directly impact upon interactions between persons, even if carried out actively by only one person.

One Person Techniques

The goal of one person techniques as with conjoint techniques is to bring about changes in repetitive and sequential dysfunctional patterns of interactions. However, one person techniques attempt to offer the advantage of system-wide impact on the client's social ecology in cases in which the entire family is unwilling or unable to take part in family therapy or the client's social ecology includes significant others not of the immediate family. A critical assumption of One Person Family Therapy is the **Principle of complementarity.** The Principle of Complementarity states that if a system is to maintain itself and its characteristic repetitive sequences of behavior, each member's behavior must coordinate with, be maintained by and be contingent upon the behavior of other members of the system. Thus, if the behavior of one person in a social ecology changes, then the other members of the social ecology also have to change their behavior.

Since the conjoint techniques outlined above were generally designed for direct intervention in a whole family setting, several new techniques were developed which allow indirect interventions through the One Person (OP).

Joining. As in the conjoint modality, joining in the one person modality consists of two phases: (a) establishing a therapeutic alliance, and (b) enactment. Joining is accomplished by the therapist behaving in a manner that permits the client/-family feel supported and their interactional patterns maintained as they occur in their everyday life. This in turn renders the therapist acceptable to the client/family. In using one person techniques, since the therapist works primarily through one person, the therapist enters the client's family or social ecology as well as directs change, throught the OP. To begin the joining process, a therapeutic alliance is established with the OP. The therapist, in the context of the therapeutic alliance, will track the family's or significant other's characteristic pattern of interaction through the OP's perceptions.

Enactment is also different when using One Person Family Therapy. Whereas in the conjoint modality, actual re-enactment of characteristic family interaction takes place, in the one person modality, since just one person is present, only an enactment analogue is possible. That is, the therapist must construct a representation of characteristic interactional patterns, in lieu of actual re-enactment which allows direct observation.

There are several techniques that have been used to elicit enactment analogues: (1) role playing by OP of the roles of family members of significant others, (2) role playing by OP and therapist of complementary roles, (3) empty chair technique from gestalt therapy, and (4) use of blackboard to sketch structural relationships.

When the OP is asked to represent her/his family or social ecology, what the OP usually represents is his/her experience of the behavior of others rather than of the self. The therapist assumes from systems theory that for the system to maintain itself, the OP must behave in a fashion that complements the reported behavior of others in the family or social ecology. When these two complements (OP's and others' behaviors) are brought together, the system has been symbolically represented and can be understood from a systemic point of view.

Once significant patterns of interaction have been enacted and the therapist has identified the most clearly complementary behaviors between the OP and significant others, the therapist is in the position to begin directing changes in patterns of interactions through the OP.

Restructuring. In the conjoint modality, restructuring takes place through direct therapist interventions to alter dysfunctional interactional patterns. In using one person techniques, in order to bring about changes in dysfunctional interactional patterns, it is necessary to begin restructuring at the intrapersonal level. The therapist does this by restructuring the OP's internalized representation of the family's and/or social ecology interactional pattern in general, and the OP's role in those interactions in particular. Techniques used to facilitate intrapersonal restructuring include Gestalt fantasy techniques, and splitting the OP's executive observant ego. Once sufficient intrapersonal restructuring has occurred, the OP is engaged as a therapeutic ally. The next step in using one person techniques is to carry out the interpersonal restructuring through the OP with the OP's active aid and participation. The techniques for interpersonal restructuring using one person techniques are similar to those described above under the conjoint modality (reframing, reversals, detriangulation, opening-up closed systems), but require the extensive use of rehearsals with the OP during the sessions. The next step is for the OP to implement her/his changed behavior through a set of homework tasks assigned by the therapist. In using one person techniques, the response to the OP's changed behavior is usually pressure to return to its previous homeostatic balance which frequently results in a crisis. At this point, the family or significant others may be accessible to the therapist and, in fact, it may be an ideal moment for the therapist to request and typically obtain therapy sessions with the client's family or significant others.

In summary, both Brief Strategic Family Therapy modalities (Conjoint Family Therapy and One Person Family Therapy) attempt to bring about symptom remission in the IP/OP and structural change in the client's family or social ecology (i.e., changes in repetitive and sequential dysfunctional interaction patterns). The principal difference between the modalities is that in the conjoint modality, the therapist aims at direct interventions in the client's family/social ecology while in the one person modality, the therapist aims at indirectly intervening in the client's family/social ecology by working with and through the one person.

In this section we have described the Strategic Structural Systems intervention for use with young adult cocaine users. We have described the Strategic Structural Systems intervention as an integration of Structural Systems engagement and Brief Strategic Family Therapy techniques. Our clinical work with the Strategic Structural Systems intervention has lead us to believe that for the Strategic Structural Systems intervention to be an effective modality, the use of Structural Systems Engagement techniques have to be used throughout the intervention process. That is, we have found that if Structural Systems Engagement techniques are used to engage into therapy client/-families that are normally resistant to therapy, it is necessary to continue to use higher levels of Structural Systems Engagement (frequently including Level 5) to maintain client/families in therapy or to re-engage them into therapy.

Our planned research is designed to experimentally test the effectiveness of a Strategic Structural Systems (SSS) intervention for the engagement and treatment of young adult cocaine users. The SSS intervention that will be tested in this study is a psychosocial modality in which "focal" problems (i.e., the specific problems targetted for intervention) are defined as (1) the engagement of the cocaine user into treatment, (2) the maintenance of the cocaine user in treatment, and (3) the elimination of drug abusing behavior by the subjects.

Subjects for this study will consist of cocaine users between the ages of 20 and 34. The experimental design for this study will include four intervention conditions. Condition 1 will consist of the application of the SSS intervention to all three focal problems, i.e., engagement, maintenance and treatment. The other three conditions will provide controls for the effects of the three focal interventions (see Table 4). Condition 2 will consist of the application of the SSS intervention to the focal problems of maintenance and treatment, but not engagement. Condition 3 will consist of the application of the SSS intervention to the focal problems of engagement and treatment, but not maintenance. Condition 4 will be a therapy control condition designed to test the effectiveness of the Structural Systems intervention therapy when compared to a widely used form of individual psychotherapy. The primary research question this study is designed to address is how effective is the integrated application of the SSS intervention [i.e., Condition 1 (engagement, maintenance and therapy)] when compared to the systematic partial application of the SSS intervention to each of the focal problems [i.e., Condition 2 (maintenance and therapy), Condition 3 (engagement and therapy), and Condition 4 (therapy control)]. The outcome measures for the study are designed to assess the effectiveness of the intervention in terms of engagement, maintenance and treatment. Assessment of engagement effectiveness will be measured by means of differential engagement rates into therapy across conditions. Assessment of maintenance effectiveness will be measured by means of differential termination rates across conditions. Assessment of treatment effectiveness will be measured by means of a clinical psychiatric interview, significant other's reports, and biological measures compared across conditions at the time of intake, termination and follow-up.

Table 4

Systematic Application of
Strategic Structural Systems Intervention
to Focal Problems of Cocaine Abuse Treatment

	FOCAL PROBLEM		
	Engagement (E)	Maintenance (M)	Therapy (T)
Condition 1 (EMT)	X	X	X
Condition 2 (MT)	O	X	X
Condition 3 (ET)	X	O	X
Condition 4 (TC)	O	O	Y

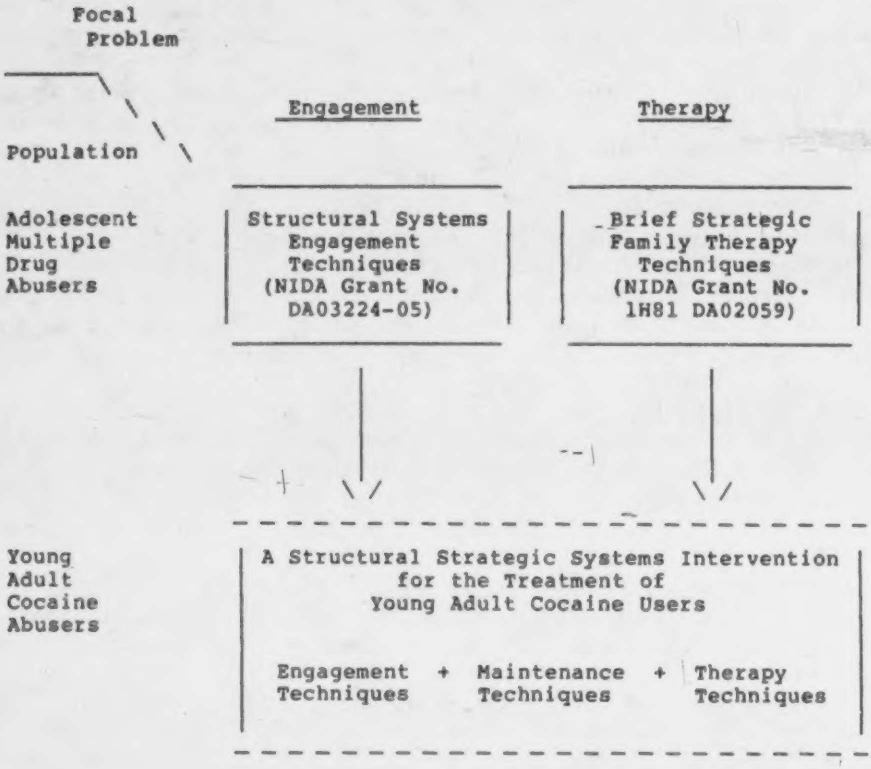
[X Intervention; O No Intervention Control; Y Therapy Control]

The experimental engagement, maintenance and therapy techniques used in this study were all developed within the same theoretical model, the Structural Strategic Systems (SSS) approach. The SSS approach is a systems, structural and strategic approach to intervention that targets at changing social systemic interactions that most directly impact on the focal problem. In our previous research using the SSS approach with adolescent drug abusers, the system most directly impacting on the drug abuser was the family. In extending our SSS approach to young adults, we will continue to view the family as the major target for structural intervention. However, we will also use techniques that we have developed as part of our earlier research to make structural interventions in the young adults' social network of significant others, such as "live ins," work peers, and social peers. Thus, as Figure 1 illustrates, this study builds on previous research and proposes to combine both engagement and therapy techniques into a single intervention modality called Strategic Structural Systems (SSS) intervention.

In our currently planned research, we have combined both the engagement and therapy techniques in the SSS intervention because each offers advantages that when combined have the potential to form a powerful intervention modality. The engagement techniques allow us to get client/families into treatment who would otherwise not come until their drug abusing behavior had developed further and worsened. These same engagement type of techniques also allow us to maintain and re-engage resistant client/families when they are applied, as needed throughout therapy. The therapeutic techniques we have developed offer the advantage of being brief and effective, as well as cost-effective. In addition, because we have developed detailed manuals, both the engagement and therapy techniques are easy to explain, understand, and replicate under research conditions.

Figure 1

Evolution of A Strategic Structural Systems Intervention for the Treatment of Adult Cocaine Users


Focal Problem
Population
Engagement
Therapy
Adolescent Multiple Drug Abusers
Structural Systems Engagement Techniques (NIDA Grant No. DA03224-05)
Brief Strategic Family Therapy Techniques (NIDA Grant No. 1H81 DA02059)
Young Adult Cocaine Abusers
A Structural Strategic Systems Intervention for the Treatment of Young Adult Cocaine Users
Engagement Techniques + Maintenance Techniques + Therapy Techniques

Senator HAWKINS. Are there typical personal, familial and physical characteristics of a potential drug abuser?

Dr. SZAPOCZNIK. Yes, I believe that there are some that have been uncovered. In children, one of the characteristics we worry about is aggressiveness. That may potentially be a predictor of later drug abuse. In adolescents, behavior problems in general, behavior problems such as disrespect, aggressiveness, promiscuity, truancy, may be predictive of drug abuse.

In families, one of the areas that may be predictive of drug abuse is parent inability to reach joint, unambiguous decisions with regard to the conduct of their children.

Senator HAWKINS. The mother and father cannot agree?

Dr. SZAPOCZNIK. Right.

Senator HAWKINS. What if it is a single parent?

Dr. SZAPOCZNIK. Well, in this case, it is very important that the rules are very firm and unambiguous. And it is when rules, whether it is by one parent or two, are vague that the child does not quite know in what direction to grow, and behavior problems begin to occur.

Senator HAWKINS. So, in your research and in your center in Miami, one of the first recommendations you give to a family is for them to be united on the rules of conduct for the children?

Dr. SZAPOCZNIK. Right.

Senator HAWKINS. And on what is acceptable and what is unacceptable.

Dr. SZAPOCZNIK. That is right. They have to be firm, although there has to be enough flexibility to negotiate with the child. Actually, it is not just a matter of telling, because if it were that easy, parents would do it more readily.

Senator HAWKINS. You could post a sign, like at the pool, "No running."

Dr. SZAPOCZNIK. Right. It is a matter of helping parents to develop these kinds of rules that are reasonable and enforceable, and then helping parents to move through the process of enforcing them.

Senator HAWKINS. What age are we talking about?

Dr. SZAPOCZNIK. I think this is true for all ages; it is true for all of us that we need clear guidelines.

Senator HAWKINS. Yes, I know that.

Dr. SZAPOCZNIK. But what is appropriate at different ages may change.

Senator HAWKINS. Is parental example good?

Dr. SZAPOCZNIK. I think that is very important, because it gives parents the moral basis to enforce certain rules.

Senator HAWKINS. We heard evidence in a hearing in Miami last year where the policeman said the children said they were getting the drugs from their mothers, which is a new phenomenon to me.

Dr. SZAPOCZNIK. Some of today's parents were members of the sixty's "flower generation", and some of these parents continue to use drugs and are making them available to their youth.

Senator HAWKINS. As to that testimony, would you agree as an expert that number one, the mothers did not like to do drugs alone?

Dr. **Szapocznik**. There is also a real problem in licit drugs that parents use, overuse and misuse, such as psychoactive medication. Such use, misuse and abuse on the part of some parents can encourage the child also to use psychoactive drugs, whether licit or illicit.

Senator **Hawkins**. I was just reminded that a child told us that firsthand, also, so it was true.

We are very proud of you, Doctor.

Dr. **Szapocznik**. Thank you.

Senator **Hawkins**. I would like to know if you know how NIDA disseminates your research findings.

Dr. **Szapocznik**. Well, from time to time NIDA has developed monographs and has encouraged us and helped us in developing publications on this work.

I think that there are a lot of other ways that research findings ought to be disseminated beyond what is being done. I think the conventional approaches have limited effectiveness. That is, if something is written in a book, it can sit on the shelf. And as you know, the structural approaches are the most effective—that is, if NIDA would work more closely with the States since they are responsible for service provision—and help the States to implement some of these kinds of research findings, implement them into their service delivery system.

Also another structural way would be to work with third-party payors such as insurance companies, and encourage insurance companies to pay for those services that have been documented to be effective through research.

Senator **Hawkins**. So you are saying pay for services that have been documented through research to be effective.

Dr. **Szapocznik**. Yes. For services that have already been documented by research to be effective.

These are two ways in which research could be implemented through organizational structures. The States is one, and the other one is third-party payors. NIDA's current emphasis on publications, while important, may be of limited value.

Senator **Hawkins**. Absolutely. Hands-on is what I am looking for.

Dr. **Szapocznik**. Exactly.

Senator **Hawkins**. How can the general public get access to your research or your experiences?

Dr. **Szapocznik**. I think that what may be needed is to translate our work into material that is more popular and accessible.

Senator **Hawkins**. So when you are on the cover of "Newsweek", is that the right magazine?

Dr. **Szapocznik**. That would be a good magazine, for sure.

Senator **Hawkins**. That would be good. But you understand you are going to be inundated, once somebody finds an expert that has hands-on, 85 percent effective rate, 100 percent when it comes to cocaine. This is something that we have been looking for and dreaming for and wishing for and paying for for a long time. And you have it. So it seems to me that there should be some way we can assist you, or NIDA be able to assist you, to disseminate information to those requests that you are going to get.

Dr. **Szapocznik**. To train others to do this kind of work.

Senator HAWKINS. Absolutely. To me, it is a dream come true.

In your experience in this field, what do you see as the trend in drug abuse as it relates to the kids?

Dr. SZAPOCZNIK. Well, unfortunately, I do not see anything good in the future in terms of what I see with the kids. As you know, we are seeing, increased cocaine use. And the most disturbing aspect of what I have seen, particularly in the last 5 years, is young kids involved in dealing. That is one of the ways in which they support their habits——

Senator HAWKINS. The kids are dealers?

Dr. SZAPOCZNIK. Sure.

Senator HAWKINS. How young?

Dr. SZAPOCZNIK. Fourteen.

The distribution network has been very effective in moving into the schools. I think that that is very sad, and very difficult to fight against.

The most encouraging trend that I have seen is the parent group movement. I think parents becoming concerned, interested and involved is a critical component of the solution to the problem.

Senator HAWKINS. I agree. But you get a single parent, take a mother than has to work and support her children, and then has to go here, too.

Dr. SZAPOCZNIK. Single parents cannot do a lot, but groups of parents, when they organize themselves, can do an awful lot in helping each other and in making changes that are necessary in the system.

Senator HAWKINS. I really like working with you, and I would like your expert opinion on what do you think we should give priority to in this upcoming reauthorization?

Dr. SZAPOCZNIK. Well, of course, you can already see my bias, family——

Senator HAWKINS. That is no bias, friend. You are in the right committee to be biased toward the family.

Dr. SZAPOCZNIK. Yes, and I think that is one of the areas that definitely ought to have priority—not only direct family work in treatment and in prevention, but also work that can support family groups, the family movements, which I think have a great deal of potential.

I think that something you were mentioning, and I definitely agree with you, is how to make these findings available to people who can use them day-to-day. That is another area that needs a great deal of support.

Senator HAWKINS. I am very proud of you, as you know. I love working with you, and I look forward to a lot more success stories.

Dr. SZAPOCZNIK. Thank you very much. I am delighted to have been here.

Senator HAWKINS. Senator Dodd, we would like to ask you to introduce our next witness, please.

Senator DODD. Just one question, if I can, for Dr. Szapocznik.

Senator HAWKINS. Oh, excuse me.

Senator DODD. Looking at the data recently of the incredible growth in poverty statistics among Hispanics nationwide in the last few years, I do not know how it pertains particularly to the situation where you are localized, but I presume it is probably not tremendously different statistically than it is nationwide.

I wonder if your center is at all focused on that rise in poverty levels as it relates to this particular problem at all?

Dr. SZAPOCZNIK. In the kind of work that we do, we have families from all levels. We have families from parents who do not read or write to parents who have doctorate degrees, and from people who are on welfare to people who can fly their own jet in for therapy.

Senator DODD. I was not suggesting that your center only focused on, nor did I suggest or hope to suggest to you that I thought this was a problem that was defined by economic circumstances. But since there is an increase in the level of poverty among Hispanic families nationwide, and there seems to be a correlating rise in the alcohol and drug abuse problems, and it runs hand-in-hand with poverty statistics in many areas, I am wondering if your center has focused at all on that unique correlation of statistics and come up with any suggestions, for instance.

Dr. SZAPOCZNIK. No, we have not.

Senator DODD. Thank you very much for your testimony.

Dr. SZAPOCZNIK. Thank you.

Senator DODD. Madame Chairman, I am delighted as well to introduce a constituent, Dr. Thomas Babor, who is an associate professor of psychology at the School of Medicine at the University of Connecticut and has been there for the last 4 years, but more significantly—I said 20 years earlier; I apologize for adding 5 years to your experience; it has been 15 years, since back in 1971—that he has been the associate scientific director of an alcohol research center in Farmington, CT which is supported by the National Institute of Alcohol Abuse and Alcoholism.

And, as I think we discovered 15 years ago, these subjects did not have the kind of attention or the appeal that other areas of research did. And the fact that we have someone who has had that many years delving into this particular area, I think is of particular importance to the committee. So I am delighted to welcome you, Dr. Babor to these hearings this morning, and we are all anxious to hear your testimony.

Dr. BABOR. Thank you.

Madame Chairman and Senator Dodd, I would like to thank you for this opportunity to be here today. I would like to say that the issue of reauthorizing NIAAA and NIDA is an issue that is close to me, having been involved almost continuously in alcohol and drug research over the past 15 years.

As a recipient of several NIAAA research grants, I believe I am fairly representative of a new generation of career researchers who have grown up with these agencies.

What I would like to communicate to you very briefly today are some impressions that the research community has of NIAAA in particular and the impact that we see of these research activities on our country's ability to deal with issues of prevention and treatment.

When NIAAA's parent institute, the National Center for the Treatment and Prevention of Alcoholism, was established in 1969, the amount of scientific attention devoted to the problems of alcohol was very meager. Few investigators would commit themselves to this field. There were no incentives to train new research scientists. There were little or no funds available to support research, and there was a limited knowledge base.

In a sense, alcohol studies at that time were as stigmatized as the condition of alcoholism itself. Unlike cancer or heart disease, alcoholism is a health problem that does not readily attract scientific interest, primarily because the training is long and arduous, the scientific prestige is not great, and the problem is so complex that it requires specialized knowledge from just about every discipline.

Under these circumstances, the accomplishments of NIAAA since its inception in 1974, have been remarkable because during this time there has been a dramatic improvement in the quantity and quality of alcohol research. There are several ways, I believe, that NIAAA has contributed to this process.

First, its research and training programs have succeeded in attracting a large number of basic scientists and clinical investigators to the field, and many of these people are now willing to commit themselves to a long-term program of research.

Because it takes years of postdoctoral training to make a productive scientist, the field is just beginning to benefit from this investment in manpower.

A second way that NIAAA has contributed to the improved climate of research is in the development of what might be called an infrastructure of people, programs and facilities. This infrastructure consists of training programs for new investigators, career scientist grants for established researchers, program project grants, information dissemination channels, and the National Research Centers.

The result has been that for the first time, there exists a nationwide network of research scientists including biochemists and biologists, psychologists and epidemiologists, psychiatrists and sociologists, who are willing to develop a professional identity with alcohol studies as opposed to their own individual disciplines. This is very important in the development of a research area, because scientists are most productive when they can feel part of a larger community of scholars.

A third accomplishment of NIAAA has been a sense of direction and purpose that it has brought to this newly emerging research community. More than other types of health research, alcohol studies need an organizing focus as well as a mechanism for coordinating effort and setting priorities.

Economic trends, social movements and innovations in health technology often raise pressing policy questions that can only be addressed by attentive and flexible leadership at the Federal level.

Why do some Native American groups have epidemic rates of liver cirrhosis?

What has been the national impact of raising the alcohol purchasing age in many States?

What treatments are efficacious enough to merit Medicare reimbursement?

What is the genetic basis of alcoholism?

How do obstetricians detect and prevent alcohol related birth defects in the children of alcohol-abusing mothers?

What are the most appropriate education campaigns, and at what point during adolescence should they be implemented?

In some cases, it takes years to find out that some education campaigns may not even be effective; they may be counter-productive. And therefore, an extreme amount of caution is, I think, warranted before jumping into media campaigns and things of this nature.

These are just a few of the questions that would remain unanswered without strong leadership on the Federal level.

In the remaining part of my statement, I would like to describe some personal examples of how NIAAA's National Research Centers Program is helping to answer some of the questions like this and how research may be contributing to this knowledge base.

The University of Connecticut Alchocol Research Center is one of nine NIAAA sponsored facilities in the country. One of the things that we have done is to identify risk factors such as familial alcoholism and antisocial personality characteristics that may someday make it possible to predict and perhaps prevent the onset and course of alcoholism in vulnerable individuals.

We were talking just before about the role of the family in alcohol abuse. We are looking at clinical samples, clinical populations, people who already have developed alcohol dependence. And here, too, family history, and family stability makes a difference. Alcoholics come from a variety of different backgrounds, and you find that alcoholics who have family support respond much better to treatment than those who do not. Perhaps they need less treatment than people who do not have family supports and a social network that is going to help them.

Similarly, alcoholics who come from a background where there is a family history of alcoholism—and only 40 percent or so of alcoholics actually have an identifiable family history—these individuals are vulnerable to developing a more virulent form of alcohol dependence, and their drinking careers, their treatment histories, are going to be much more serious and costly. These are some of the things that we have been looking into.

Finally, our center has been actively involved in the development of low-cost early intervention procedures capable of being implemented on a widescale basis by nonspecialized health workers in primary care settings and places of employment.

What we are proceeding from is an early intervention model that was first developed in Sweden. This consists of screening for biochemical markers, identifying people at risk and making them aware of the fact that they are drinking too much. This approach can have a demonstrable effect on morbidity and mortality in the years ahead, if you can get people before they become alcohol-dependent.

In closing, I would like to invite members of this committee and your staffs to visit our Alcohol Research Center. I think you might be intrigued by some of the things that we are doing, and it will provide a good example of how researchers are attempting to solve some of these difficult problems.

Thank you.

[The prepared statement of Dr. Babor follows:]

STATEMENT

BY

THOMAS F. BABOR, PH.D., M.P.H.

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ON

REAUTHORIZATION OF

THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

BEFORE THE

UNITED STATES SENATE SUBCOMMITTEE ON CHILDREN,

FAMILY, DRUGS AND ALCOHOLISM

THURSDAY, FEBRUARY 20, 1986

Senator Hawkins and Members of the Subcommittee:

Let me begin by expressing my gratitude for the opportunity to testify at this hearing. The issue of reauthorizing the research mission of NIAAA is one that I can speak to from personal experience, having been involved almost continuously in alcohol and drug research since I received my doctorate in psychology in 1971. As the recipient of several NIAAA research grants during this period, I believe I am fairly representative of a new generation of career scientists who have grown up with NIAAA. What I would like to communicate to you today are my own impressions of how this agency is viewed by the scientific community, and the impact its research activities have had on this country's ability to understand, treat and prevent alcohol problems.

When NIAAA's parent institute, the National Center for the Treatment and Prevention of Alcoholism, was established in 1971, the amount of scientific attention devoted to the problems of alcohol was meager. Few investigators would commit themselves to long-term programs of either basic or clinical research in this field. There were no incentives to train new research scientists, little or no funds were available to support research, and there was a limited knowledge base on which to build explanatory theories and health interventions. In a sense, alcohol studies were as stigmatized as the condition of alcoholism itself. Unlike cancer or heart disease, alcoholism is a health problem that does not readily attract scientific interest, primarily because the training is long and arduous, the scientific prestige is not great, and the problem is so complex that it requires specialized knowledge that cuts across the gamut of traditional scientific disciplines.

Under these circumstances, the accomplishments of NIAAA since its inception in 1974 seem all the more remarkable, because there has been a dramatic improvement in both the quantity and the quality of alcohol research over the last 12 years. There are three ways, I believe, that NIAAA has contributed to this process.

First, through its research and training programs, NIAAA has succeeded in attracting to the field large numbers of basic scientists and clinical investigators, many of whom have been willing to commit themselves to a long-term career in alcohol research. Because it takes years of postdoctoral training to make a productive scientist, the field is just beginning to benefit from this investment in manpower training. Indeed, a 1984 report to the Institute of Medicine (1) concluded that: "NIAAA's innovative uses of relatively meager research funds to attract talented investigators in the biobehavioral sciences to studies of alcohol-related problems are especially noteworthy" (p. 27).

Second, NIAAA's presence has helped to creat an infrastructure of people, programs and facilities that is crucial to progress in this area. This infrastructure consists of training programs for new investigators, career scientist grants for established researchers, program project grants, information dissemination channels, and the national research centers. The net result has been that, for the first time, there exists a nationwide network of research scientists, including biochemists, biologists, psychologists, epidemiologists, psychiatrists, sociologists, and even anthropologists, who have developed as much of a professional identity with the field of alcohol studies, as they have with their own disciplines. This is an extremely important development because scientists are most productive when they are part of a larger community of scholars.

A third accomplishment of NIAAA is the sense of direction and purpose federal leadership has brought to this newly emerging research community. More than other types of health research, alcohol studies need an organizing focus, as well as a mechanism for coordinating effort and setting priorities. Economic trends, social movements and innovations in health technology often raise pressing policy questions that can only be addressed by attentive and flexible leadrship on the federal level. Why do some Native American groups have an epidemic rate of liver cirrhosis? What has been the national impact of raising the alcohol purchasing age in many states? What treatments are efficacious enough to merit Medicare reimbursement? What is the genetic basis of alcoholism? How do obstetricians detect and prevent alcohol-related birth defects in the children of alcohol-abusing mothers? These are just a few of the questions that would remain unanswered without strong leadership on a federal level.

In the remaining part of my statement, I would like to share with you some personal examples of how NIAAA's National Research Centers Program is helping to answer questions like this, and how this research is contributing to the knowledge base that will be crucial to the development of informed health policy. The research program at the University of Connecticut Alcohol Research Center, one of nine such facilities in the country, has identified several risk factors, such as familial alcoholism and antisocial personality characteristics, that may someday make it possible to predict, and perhaps prevent, the onset and course of alcoholism in vulnerable individuals. Another program at our center has identified childhood characteristics that differentiate between alcoholics who become violent when they drink and those who do not. This information may help to clarify the learning processes that account for alcohol-related domestic violence. Finally, our center has been actively involved in the development of low cost, early intervention procedures capable of being implemented on a wide scale basis by nonspecialized health workers in primary care settings. These procedures, such as brief counseling and the provision of self-help manuals, could help to mobilize a large segment of the medical community who have traditionally been reluctant to engage in preventive action against the pervasive alcohol abuse they encounter in health settings and work environments. Because these research programs take years to develop and implement, I can say unequivocally that they would not have been undertaken without the support and encouragement of NIAAA.

Between 1980 and 1984, no fewer than three independent committees, two of them appointed by the prestigious Institute of Medicine (1,2,3) reviewed different aspects of the federal research mission dealing with alcohol and mental health disorders. All concluded that alcohol research is not funded at a level commensurate with the economic costs it imposes on society. These costs were recently estimated (4) to be almost $90 billion in 1980. And what is of equal importance to this hearing, all committees had specific praise for the accomplishments of NIAAA under these difficult circumstances. I believe that the research community that works closely with NIAAA agrees with these conclusions. Because of the leadership and professionalism it has demonstrated over the past 12 years, and the tangible accomplishments I have spoken of, I believe that reauthorization of NIAAA and its companion institutes is crucial if the burden of illness caused by alcohol is to be reduced in the years ahead.

In closing, I would like to invite the members of this committee to visit our research center if they would like to see firsthand the kinds of NIAAA-sponsored research being conducted to answer basic questions about alcoholism and to inform health policy on a national level. Thank you again for your interest.

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Senator HAWKINS. Thank you, Dr. Babor. I have no questions, and I am pleased to have your testimony. Thank you for being with us.

The information we have gathered here today will be helpful in guiding us to the reauthorization of NIDA and NIAAA.

Senator Dodd.

Senator DODD. I just have a question or two.

Just quickly, Dr. Babor, if you could, how about recent demographic trends and trends in alcohol consumption patterns? How will they affect the research priorities at all? Can you give us any indication of that?

Dr. BABOR. Well, we have all been reading about the coming of age of the "baby-boomers." As we see this bulk of people maturing into their thirties and forties now, I think we are going to see a shift in drug abuse patterns and a shift in the treatment needs of this population. In the years ahead, we are going to see an escalating demand for alcoholism treatment.

The average age of treatment in almost all treatment populations that you can study going back for a century is about 40 years old. As our population starts to age, we are going to have a much larger group of individuals within the population who are reaching that age who have a history of poly-drug use and alcohol use and are going to be putting demands on the health care system. So I think one priority within NIAAA should be to intensify its research efforts in the area of treatment.

Senator DODD. Well, you have already indicated just by that, I suppose, a new area to go into. You mentioned a long list of things where research is being done. As someone who is out there in the field—and Dr. Szapocznik, as well, from your center in Miami, may want to respond to this—could you share with us briefly this morning where you think there are areas that maybe there is no enough initiative or not enough encouragement coming from the Federal agencies, where you would like to see us go a little bit.

Do you have any recommendations in that area?

Dr. **Babor**. There have been several reviews of the research priorities in the last few years by the National Institute of Medicine. Looking at NIAAA's research portfolio, their recommendations were to intensify efforts in many of the areas where they are spread thin.

But there is a reasonably good balance within that agency. If there is a deficiency in the alcohol and drug area, I think it is on the level of societal changes which take place, which are almost impossible to predict ahead of time. But these changes should be monitored. An example is the anti-smoking movement that has taken place. The anti-smoking movement was stimulated by research findings on the link between cancer and smoking. It precipitated some significant changes in attitude, plus a grassroots movement against media advertising of cigarettes. As a consequence we have seen a change in the onset of cigarette smoking, at least among males.

Similarly, the drunk driving movement in this country was a grassroots movement, some of it coming from a community level and State level, which I think is now having an effect on the availability of alcohol and the amount people consume in social situations.

These kinds of trends are extremely important to study on a national level, particularly by epidemiologists and social scientists, and they should be monitored very carefully to learn what we can from the natural process that society has to protect itself. Every 10 or 15 years, there seems to be a remedial process that goes on to correct extremes within society, and I think we are viewing some of those trends now. We should study them more closely to understand how they operate and perhaps how these agencies might be able to take a role in leading these public health movements.

Senator **Dodd**. Thank you.

Dr. Szapocznik.

Dr. **Szapocznik**. I agree with Dr. Babor that these large scale social movements are very important. One of the difficulties is that the agencies—and I am more familiar with NIDA than I am with NIAAA—are oriented toward rigorous research. Unfortunately, the methodology need to carry out systematic interventions in these movements, is in its infancy. The Institutes are not set up in such a way that they can fund programs that are in their infancy, because research grants have to go through a peer review process that is very rigorous. In order to get through the peer review process, a study has to be in an area where the methodology is fairly well-developed, and that means an area that is more conventional. This keeps the Institutes away from the opportunity of studying the more nonconventional processes that emerge, as well as these largescale social movements.

Senator **Dodd**. Thank you very, very much.

Dr. **Szapocznik**. Thank you very much.

Senator **Dodd**. Thank you both very, very much for coming down. We appreciate your testimony.

[Additional material supplied for the record follows:]

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STATEMENT OF

AMERICANS FOR SUBSTANCE ABUSE PREVENTION

before the

Subcommittee on Children, Family, Drugs and Alcoholism
U.S. Senate

On reauthorization of NIDA and NIAAA

February 20, 1986

Madame Chairman and Members of the Subcommittee:

Thank you for this opportunity to discuss the renewal of the program authorities for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA).

I am speaking on behalf of Americans for Substance Abuse Prevention (ASAP), a 20,000 strong, nonprofit association. Our goals include making the American public more aware and better educated about the dangers and warning signs of alcoholism and drug addiction and encouraging research dealing with alcohol and drug-related issues.

As it considers reauthorization for NIAAA and NIDA and proposed funding levels for these institutes, ASAP urges this subcommittee to consider the massive impact of these diseases in both societal costs and human tragedy: Some examples:

o $170 billion in 1984 in lost production, medical care, crime, social welfare costs and motor vehicle accidents.

o 50 percent of patients admitted to hospitals with other diagnoses are suffering from alcohol and drug problems.

o 10 percent of this nation's death toll.

Since their establishment in the early 1970s, the institutes have catalyzed a substantial body of research and information on which to begin reducing the prevalence and impact of these life-threatening diseases. ASAP believes that alcoholism and drug abuse are primary disorders which require their own research and treatment focus. One recommended approach would be to allow the authorities of both NIAAA and NIDA to lapse, "kicking in" Section 301 of the Public Health Service Act. These institutes would then be auhorized exactly as the National

Institute on Mental Health (NIMH) and the prestigious NIH institutes. Equating alcoholism and drug abuse research with the efforts of NIH would be welcome scientifically and politically. Year-to-year reauthorization hearings would no longer be necessary. A secondary approach, we would also support, is to simply reauthorize NIDA and NIAAA for three or more years.

Research

Research for these diseases has been grossly underfunded compared to what is spent for other diseases. The American Assembly in its Public Policy on Alcohol Problems emphasized that NIAAA's research budget should be doubled as soon as possible and steadily increased thereafter. Enactment of the Gramm-Rudman Deficit Reduction Act, implemented through President Reagan's sequester order, further limits the scope of research supported through NIDA and NIAAA. We urge that the federal excise tax on beer and wine be raised to help fund NIAAA and that a portion of the Department of Justice's Assets Forfeiture Fund and U.S. Customs Drug Forfeiture Fund be utilized to help fund NIDA.

Given the restricted funding levels for the two institutes, we recommend that some research projects be given high priority.

1. Matching individuals to the appropriate treatment levels.
2. Evaluating the effectiveness of different treatment methods.
3. Developing assessment tools and procedures to aid in making differential diagnoses.
4. Developing methods to increase the detection of chemically dependent individuals by health care providers and establishing effective intervention methods.
5. Developing longitudinal studies of cocaine abuse and its effects.
6. Developing prevention, early intervention and treatment programs for children of alcoholics and other drug abusers.

7. Exploring presenting problems, treatment issues and outcomes of adolescents harmfully involved in alcohol and other drugs.

8. Continuation of the brain research on drug abuse behavior.

9. Continuation of the research into physiological and biomedical factors that may indicate a predisposition to alcoholism, including brain waves, enzymes, and blood levels of alcohol metabolites.

10. Continuation of research on the links between alcohol and drug abuse and many digestive, brain and other medical disorders as well as trauma.

11. Surveying the extent, quality and problems of alcohol and drug treatment in Health Maintenance Organizations and Preferred Provider Organizations.

12. Implementation of a junior high school survey to assess the incidence and prevalence of alcohol and drug use among this population.

13. Expansion of the Drug Abuse Warning Network to permit a representative national sample of emergency room admissions and coroners reports on drug use and related health problems.

14. Assessing the treatment complexities associated with polydrug abuse and developing effective methods of treatment.

15. Identifying barriers to treatment and developing strategies for overcoming them.

16. Developing research on the most cost-effective and beneficial prevention programs.

17. Continuation of AIDS research and information dissemination program.

National Data Gathering

With the development of the block grant systems, states are no longer required to uniformly report data to NIAAA or NIDA. This lack of a comprehensive national data base, including all public and private programs, makes it difficult to know how many people are being treated, what their alcohol and drug problems are, where they are being treated and the like. We urge restoration of the National Drug and Alcoholism Treatment Utilization Survey, NIDA's Client Oriented Data Acquisition Process and other national data gathering studies.

National Clearinghouse

ASAP understands that President Reagan's sequester order calls for a 23 percent reduction below appropriated levels in funding for the National Clearinghouse for Alcohol Information. We urge that funding levels for the clearinghouses be restored to appropriate levels. The clearinghouses are a vital link in disseminating the research findings to the health care and scientific communities, and they are a major resource accessible to anyone who seeks information about these deadly, but treatable diseases.

If this nation is to discover the underlying causes of and best treatments for alcoholism and drug abuse disorders and strengthen prevention efforts, maintaining NIDA and NIAAA an independent institutes equal to the other national institutes is critical.

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Statement of

CHRISTINE LUBINSKI

on behalf of the

NATIONAL COUNCIL ON ALCOHOLISM, INC.

before the

Subcommitte on Children, Family, Drugs and Alcoholism

U.S. Senate

On Reauthorization of the National Institute on Alcohol Abuse and Alcoholism

March 4, 1986

The National Council on Alcoholism is the leading voluntary health organization working nationwide to prevent and reduce alcoholism and alcohol-related problems. NCA's two leading missions are public education and public advocacy. We have 184 state and local affiliate councils on alcoholism which provide information and referral services to families and individuals with drinking problems, and many of these local councils conduct prevention and education programs and involve citizens in grassroots advocacy efforts.

Since its inception with the mandate of the Hughes Act, NIAAA has acted as a focal point and policy voice for federal efforts to understand alcoholism and alcohol-related problems and their impact on individuals, families and the community at large. The National Council on Alcoholism has acted as a long-time supporter of NIAAA. From our perspective, NIAAA represents the heart of the federal alcoholism effort, as it illustrates the strong, ongoing commitment of the federal government to address a major health problem while providing funding for research which may hold the key to new and innovative strategies to identify, to treat, and ultimately, to prevent alcoholism and alcohol-related problems.

The 1984 Institute of Medicine Report, "Research on Mental Illness and Addictive Disorders: Progress and Prospects" indicates that mental disorders, alcoholism and drug addictions profoundly disrupt the lives of 30 to 45 million people in the nation each year, with conservative estimates of annual expenditures for direct health care at $20 billion and total economic costs at $185 billion. The 1984 Research Triangle Institute in consultation with ADAMHA report on "Economic Costs to Society of Alcohol and Drug Abuse and Mental Illness" estimated the cost to the nation of alcohol abuse alone in 1983 to be $116.7 billion. The prestigious IoM report goes on to echo the concerns of a number of government and private sector studies of the past five years in expressing concern for the limited amount of research now possible on disorders under the ADAMHA umbrella, given their enormous costs to society, and recommends substantial and steady increases in support for ADAMHA research and research training over a five year period.

The 1987 President's request for NIAAA is $68.8 million -- including $56.6 million for research; $1.3 million for reseach training; and $10.9 million for direct operations. Although this request reflects an increase of $1.9 million, or 2.8% over 1986, this small increase must be viewed in the context of the 4.3% reduction in NIAAA programming for 1986 under the Gramm-Rudman-Hollings amendment. In this context, the President's request represents a $1.4 million reduction over the 1986 appropriation level before sequestration. The research request would hold the number of new and competing grants at 74, compared to 100 in 1985 and 1986 -- a 26% reduction.

Clearly, the President's FY 87 budget request compounded by the automatic reductions mandated under the Gramm-Rudman-Hollings amendment represent a significant retreat from the Institute of Medicine report goals as well as the Congressional commitment to enhancing alcoholism research reflected by substantial increases in NIAAA appropriations over the last three years. Regrettably, this retrenchment comes at a time when the promise for research findings which might contribute significantly to the alleviation of alcoholism and alcohol-related problems in the nation is greater than ever. Research is providing increasing evidence that heredity is a major contributing cause of alcoholism and alcohol abuse in a large proportion of cases. There are important studies under way to analyze the differences among subgroups of the population in terms of drinking behavior and the incidence of various types of alcohol problems in order to identify subgroups at higher risk for alcohol problems. Such knowledge ultimately may lead to the development of more effective treatment approaches and prevention strategies targeted to populations at high risk. Relatively new prevention research which explores the way controlling the availability of alcohol can contribute to a reduction in alcohol-related problems offers a fresh and complementary area of study to more traditional biomedical and educational initiatives.

Steady but modest progress has been made in increasing the alcohol research budget over the past several years. However, the 1984 Institute of Medicine recommendation that the research and research training budget of NIAAA be increased to $100 million in constant 1983 dollars remains a distant goal. The Administration's proposal for 1987 which would provide for only 74 new and competing grants to be awarded at 84 percent of council recommended amounts clearly represents a severe setback in the goal of steady progress towards a more reasonable level of funding. An additional reduction in funding from this level, if triggered under the Gramm-Rudman-Hollings amendment, could do irreparable harm to the integrity of the federal alcohol research program.

As the authorizing subcommittee with primary responsibility for providing congressional leadership and direction to NIAAA and NIDA, we urge you to draft reauthorization legislation which offers security and the promise of continuous steady growth to the Institutes. Because of the fluctuating budget picture with varying future deficit projections, we also encourage you to provide the appropriations committee with as much flexibility as possible in determining appropriate funding levels for NIAAA during the lifetime of the authorization.

From this perspective, we recommend a multi-year reauthorization of at least three years under Section 513 to send an important signal to the scientific and research communities, as well as the public at large, demonstrating an ongoing federal commitment to support critical research and prevention efforts through a discrete research institute on alcohol. Further, we recommend an authorization level for fiscal year 1987 of $78 million as a funding level consonant with the Institute of Medicine recommendation. Further, we suggest that funding levels for subsequent years in the multi-year authorization be open-ended. NIAAA reauthorization legislation of at least three years with a fiscal year 87 funding level of $78 million for research with open-ended funding in the out years will demonstrate the authorizing Committee's support for ongoing growth in NIAAA's research capacity while allowing the appropriations committee sufficient latitude to consider NIAAA funding levels within the context of budget exigencies which may occur over the next several years.

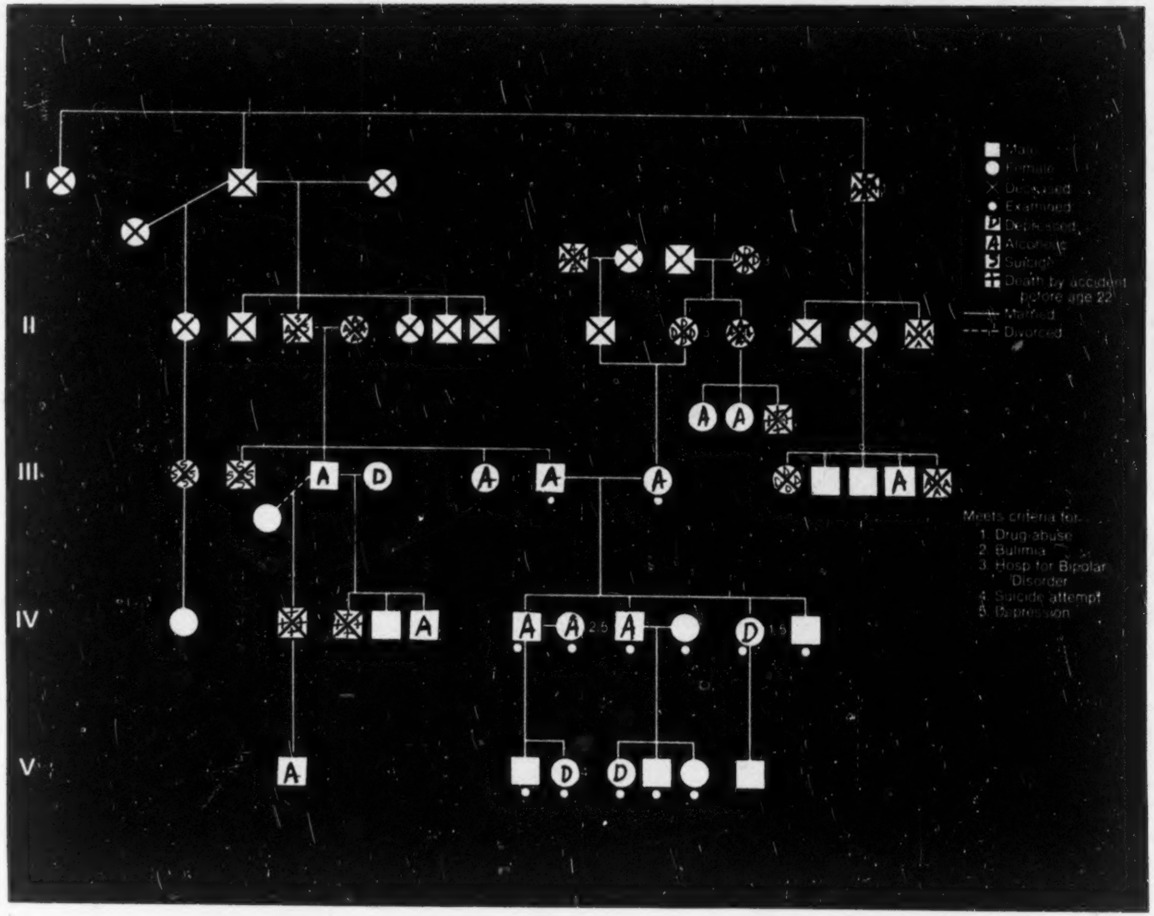
A commitment to disease prevention and health promotion has long been a hallmark of this Committee's work. In this regard, we encourage you to underscore your support for efforts aimed at the prevention of alcoholism and alcohol-related problems by providing a separate authorization for prevention/knowledge transfer in the NIAAA renewal bill. Currently, NIAAA prevention activities as well as collaborations with private sector organizations to disseminate alcohol-related health information to key target populations and to the general public are funded through the direct operations budget. The most substantial reductions in Institute activities, both under Gramm-Rudman-Hollings amendment and under the President's 1987 request occur in the direct operations line item. It is precisely in these activities, which nuture important partnerships with the private sector in the generation of public education and prevention activities in local communities, that the efforts of NIAAA are most immediately visible and meaningful to the

American public. These cuts threaten to severely curtail that visibility as well as the hope and energy it engenders in individuals, families and communities committed to reducing alcohol-related problems. Moreover, the financing of prevention efforts under the same line item with NIAAA staffing and other basic administrative costs makes little sense as it places valuable prevention initiatives in competition with the maintenance of NIAAA's basic management and operational functions. A discrete prevention/knowledge transfer authorization would protect NIAAA's prevention activities from disproportionate cuts and underscore the high priority the federal government places on the prevention of alcoholism and alcohol-related problems.

The last NIAAA reauthorization bill reflected the Committee's interest in the restoration of the clinical training program at NIAAA, and we urge you to reiterate that concern in the legislation presently under consideration. Advances in research are happening so rapidly and research results which hold important implications for treatment need to be disseminated to providers -- that dissemination of information is a federal, NIAAA responsibility, and clinical training is one of the ways NIAAA can fulfill that mandate.

The NIAAA reauthorization bill for fiscal years 1985 and 1986 also called for demonstration projects in alcohol abuse and alcoholism. We again recommend that this demonstration authority be reauthorized at the Senate's original funding request of $10 million. The enormous task of administering an adequate and quality service delivery system has left the States with few if any additional resources to improve upon or experiment with innovative and challenging new programs in the prevention and treatment areas. Federal support for demonstration projects is not only, in our view, an appropriate federal role, but also an integral component for the building of a strong federal-state partnership and can represent a key form of technical assistance rendered to the States.

Billions of dollars can be saved in public and private expenditures for treatment and rehabilitation of alcoholics and their families, and in increased productivity and reduced property damage, if alcoholism and other alcohol-related social and health problems are prevented before they begin or develop to advanced stages. Major research advances over the last decade holding great import for prevention, intervention and treatment have been coupled with an unprecedented rise in public awareness and support for the alleviation of America's alcohol problems. We now face the opportunity and challenge of dramatically reducing the toll of alcoholism in our lifetime. A robust alcohol research and prevention effort, embodied in the National Institute on Alcohol Abuse and Alcoholism, is certainly one of the keys to this challenge.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1. Drug abuse
2. Bulimia
3. Hosp for Bipolar Disorder
4. Suicide attempt
5. Depression

STATEMENT FOR THE RECORD

BY

NATIONAL ASSOCIATION OF STATE ALCOHOL AND
DRUG ABUSE DIRECTORS

ON

REAUTHORIZATION OF THE NATIONAL INSTITUTE ON DRUG ABUSE
AND
NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

PRESENTED TO
SENATE SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM
MARCH 3, 1986
(Hearing Date, February 20, 1986)

Dear Madam Chairman and Members of the Subcommittee:

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) is pleased to have the opportunity to submit a statement for the record on the reauthorization of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). NASADAD is a not-for-profit organization whose membership is comprised exclusively of the officially designated State agencies for alcoholism and drug abuse treatment and prevention. The State agencies rely on the Federal Institutes to assist the States in carrying out their alcohol and drug treatment and prevention service responsibilities by supporting applied research on treatment and prevention strategies, developing public service campaigns, providing technical assistance via national and regional conferences and training seminars, collecting data and developing Federal policy in areas such as public and private financing for treatment services and the Acquired Immune Deficiency Syndrome (AIDS) as it relates to intravenous drug use.

STATE ALCOHOL AND DRUG ABUSE AGENCIES

While several State alcohol and drug abuse agencies were in existence prior to 1970, most were created in response to Congressional action i.e., enactment of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972. These State Agencies have the responsibility to plan and administer a statewide system of alcoholism and/or drug abuse prevention and treatment services.

Under the Omnibus Reconciliation Act of 1981, which created the Alcohol, Drug Abuse and Mental Health (ADMS) Block Grant and significantly revised the purpose of NIAAA and NIDA, the mandate for Single State Agencies was repealed. However, we are pleased to inform you that each State has chosen to retain this State structure in order to effectively coordinate State alcohol and drug abuse treatment and prevention services, including administration of the relevant portion of the Federal ADMS Block Grant which was recently renewed for a three year period by P.L. 98-509.

STATE-FEDERAL RELATIONSHIP

Although NIAAA and NIDA no longer have primary responsibility for the Federal alcohol and drug services programs, the State Alcohol and Drug Agencies continue to have a strong working partnership with NIAAA and NIDA. This relationship was initially one in which the Federal Government provided national leadership and stimulated State and local government participation in the development of a well-coordinated and comprehensive alcoholism and drug abuse services delivery system. Although the Federal-State partnership has been preserved over the past two decades, the role that each level of government plays has changed dramatically.

When the Federal-State partnership was formed, State alcoholism authorities and State drug abuse agencies were generally small, had limited authority and low visibility within their State government. State and local financial support of community based service programs was minimal or non-existent. In the past decade the States have assumed an ever increasing role in the administration and monitoring of not only State and local revenues but also the federal categorical monies awarded for the support of alcohol and drug prevention and treatment services. When ADMS Block Grant program was authorized in 1981, the States assumed total responsibility for the administration of these Federal treatment and prevention monies.

In conjunction with the authorization of the ADMS Block Grant, the Institutes' mission underwent a major transformation. Whereas the

Institutes' previous emphasis had been jointly placed on the services and research programs, after the ADMS Block Grant was authorized the research program became a major focus of NIAAA and NIDA. The national clinical training programs were also dismantled due to lack of funding support from the Administration and Congress. Initially, the NIAAA and NIDA data collection efforts wereas also negatively impacted due to the elimination of Federal reporting requirements as a condition of receipt of Federal funds. Throughout this major transformation, however, the Institutes' Federal leadership and knowledge development and transfer activities were continued and the importance of these efforts were emphasized by the Congress.

REAUTHORIZATION OF NIAAA AND NIDA

The Institutes' current research authority expires on September 30, 1986. Although a bill to reauthorize the Institutes has not yet been introduced in the Congress, it is our understanding that the Chairman is in the process of developing the legislation. We would like to offer the following recommendations for legislative provisions related to the reauthorization for the Chairman's and the Committee's consideration.

PERIOD OF AUTHORIZATION AND FUNDING LEVELS

NASADAD recommends that the Institutes be reauthorized for a three year period. An extended authorization would provide needed continuity and stability for Institute programs and signal Congressional support for these programs in the research community and the field. We also suggest that the authorization level for FY 1987 should be $78 million for NIAAA and $90 million for NIDA. We propose that "such sums as needed" be authorized for the succeeding years. While we recognize the need for fiscal austerity, we also know that the economic costs to our society of alcohol and drug abuse in 1983 were $176.4 billion; evidence of a massive problem which is simply not going to disappear of its own volition.

We are not alone in our support for authorization levels that permit a moderate increase in these research programs. The October, 1984 report by the Institute of Medicine, entitled "Research on Mental Illness and Addictive Disorders: Progress and Prospects" concluded that "the amount of research on the disorders and health-related behaviors in the ADAMHA domain is much too low, given their enormous costs to society. Since 1966, the real level of Federal support has dropped markedly, even as research opportunities and available scientific personnel have expanded." The Institute of Medicine also went on record in noting that "several lines of reasoning converge to suggest that relatively conservative appropriate targets for levels of support would be in constant 1983 dollars: NIAAA, $100 million; NIDA, $100 million." We strongly believe that the FY 1987 authorization levels proposed by NASADAD would allow NIAAA and NIDA to take advantage of the considerable research opportunities currently before them; research which is at an exciting and productive stage, but remains unfunded due to a lack of sufficient monetary support. In addition, these sums would support the Institutes' roles in national leadership and information dissemination related to alcohol and drug problems.

NEED FOR SEPARATION OR PROTECTION OF PREVENTION AND KNOWLEDGE TRANSFER ACTIVITIES CURRENTLY LOCATED IN THE DIRECT OPERATIONS LINE ITEM

NASADAD is acutely concerned that the prevention and knowledge transfer activities mandated by the Congress and located within NIAAA and NIDA's direct operations line item are being disproportionately reduced by the Institutes in order to maintain personnel and procurement needs. While we are sensitive to the personnel and procurement needs of the

Institutes, we and the general public are dependent on the public service campaigns, technical assistance and information dissemination activities carried out by the Institutes with monies located in the direct operations line item. The States, in particular, rely on the Institutes assistance in coordinating and supporting prevention activities on a national level.

Our recognition of the need to protect the prevention and knowledge transfer monies is based on the fact that when the 4.3 percent reduction mandated by the Gramm-Rudman-Hollings balanced budget legislation was applied to the direct operations line item, personnel and procurement activities were protected while NIDA's technical assistance, printing budget and prevention programs were reduced by 20 percent and NIAAA's by an equal or greater amount. It is our understanding that the NIAAA clearinghouse contract will be reduced by approximately 25 percent as a result of the 4.3 percent reduction in the direct operations line item.

We propose that either a new line item, for prevention and knowledge transfer activities be authorized as recommended by the NIDA Advisory Council at its January, 1986 meeting, or that the conference report accompanying the renewal legislation specifically direct the Institutes to refrain from reducing the prevention and knowledge transfer activities by an amount greater than the reduction incurred by the other activities supported by the direct operations line item. We have already lost one-fifth of these important activities at NIDA and NIAAA.

NEED FOR INCREASED SUPPORT FOR APPLIED RESEARCH ON TREATMENT AND PREVENTION SERVICES

NASADAD is also concerned that the amount of research monies awarded to applied research grants on prevention and/or treatment services is severely limited. While we do not believe that the research currently being funded by the Institutes is unworthy of support or will not ultimately lead to improvements in the fields of alcoholism and drug addiction and abuse, we do advocate that applied research on treatment services and prevention strategies is not being supported at a level commensurate with its importance and value to the States and local service providers. Since we would be inflicting damage on the current research being conducted by the Institute if we proposed that all new research monies be given to the investigation of treatment and prevention services, wer simply ask the Subcommittee to recognize this imbalance and direct that any new monies be allocated more equitably to the support of practical, applied research on services.

The following areas of applied research would provide practical information to the treatment and prevention communities, including: how treatment efficiency can be increased without sacrificing quality, a determination of which treatment approaches are most appropriate for what particular types of clients; studies of the non-treatment factors which may be related to recovery; studies of the treatment problems of the dual-addicted person; effectiveness of K-12 school based prevention approaches and the development and analysis of community-based prevention strategies which seek to impact behavior related to alcohol and drug use.

DATA COLLECTION AND EPIDEMIOLOGY

Another vital function of the Institutes is that of supporting State data collection and epidemiology activities on a national level. NASADAD believes it is crucial for NIAAA and NIDA epidemiological and other data collection programs to be fully supported by the Congress. Additional data must be collected on the incidence and prevalence of alcohol and drug use by junior high school students. Also, information needs to be gathered to fill in the gaps in current information on the use of drugs by ethnic minorities, school drop-outs and other significant populations. With regard to treatment oriented data collection NASADAD is currently working cooperatively with the Institutes to encourage States to voluntarily provide already existing information on treatment services and clients. While we have been able to collect limited data on prevention services, this effort deserves increased attention including its own systematic reporting system.

FEDERAL ACTIVITIES

Many demands and expectations are placed on the Institutes by the Congress, constituent groups and the general public by virtue of their unique position in the Federal government and access to a wealth of expertise and resources. An example of the multi-faceted leadership role which the Institutes must undertake is related to the current dilemma present in the relationship between the Acquired Immune Deficiency Syndrome (AIDS) and intravenous (IV) drug use. NIDA has asserted a leadership role by encouraging the Centers for Disease Control to implement a significant change in the method of compiling data collected on AIDS cases which has led to an improvement in the detection of the numbers of AIDS victims who have an IV drug use connection. In order to increase understanding of the extent of this problem and to develop means for reducing the further spread of the virus through intravenous drug use, NIDA has also convened meetings of State alcohol and drug agencies and local treatment providers to exchange information and strategies. Pamphlets describing the IV drug use connection have been developed and distributed by NIDA. In addition, NIDA is working on the development of a manual for treatment providers and plans to conduct regional workshops on the manual's contents for State agency staff and treatment providers.

Since the State alcohol and drug agency directors must play a similar leadership role at the State and local level, the NASADAD Board of Directors recently requested the Institutes to provide funding to operationally research the relationship between the admission of high risk populations to treatment and the subsequent reduction in the number of individuals afflicted with AIDS. Additional funding support is essential in order to immediately expand treatment capacities to study the impact of such treatment in reducing AIDS cases. The NASADAD Board also requested that the Federal government support the establishment of three AIDS research and resource centers to coordinate AIDS research efforts and disseminate findings/information on a regional basis. It was recommended that the regional centers be established in New York, Illinois and California, States which have ongoing research activities already in place or planned. We feel that NIDA's support for the States in their examination of this deadly illness is an appropriate one.

We encourage the Congress to recognize and reinforce the Federal leadership role of NIAAA, NIDA and ADAMHA. These Federal agencies not only serve as the premiere research programs on alcohol and drug abuse, but they also play a critical role in the development of public service campaigns, other prevention services, national data collection, policy development and technical assistance through regional conferences and training sessions. We as State Directors look to the Institutes for information on the most effective new treatment strategies for various types of clients, as well as an evaluation of education and community prevention projects. The general public looks to the Institutes for basic information on alcohol and drug abuse through pamphlets, other materials and public service campaigns launched by the Institutes under Congressional direction and support.

Before we conclude our remarks, we would like to specifically applaud and thank the Congress for its authorization of the Alcohol, Drug Abuse and Mental Health (ADAMHA) Advisory Board. This Board recently held its first meeting in the Washington, D.C. area. The Board was authorized by Public Law 98-509 after Congress had assessed the need for the Institutes and ADAMHA to continue to assist the States in carrrying out their national leadership role in the area of alcohol and drug abuse services. The Council is charged with the responsibility to assess periodically national needs for alcoholism, alcohol abuse, drug abuse and mental health services and to advise the Congress, ADAMHA and HHS on the extent to which those needs are being met by State, local and private programs receiving funds under Title V and Part B of Title XIX of the Public Health Service Act. Both the NIAAA and NIDA Advisory Councils have an official Liaison Member appointed to the Advisory Board who will inform their respective Councils of the recommendations of the Advisory Board and any action which NIAAA and NIDA may need to undertake related to those recommendations. We anticipate that the recommendations developed by the new Advisory Board will be of great value to the Administration, the Congress, the States and the alcohol and drug abuse field.

We would like to thank the Chairman and Members of the Subcommittee for their dedication and understanding of the tragic illnesses of alcoholism and drug addiction. Indeed, no one is immune from the enormous problems and costs associated with those illnesses.

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19 February 1986

Honorable Paula Hawkins
Chairwoman
Subcommittee on Children, Family, Drugs
  and Alcoholism
639 Hart Senate Office Bldg.
U.S. Senate
Washington, D.C. 20510

Dear Chairwoman Hawkins:

The American Psychiatric Association, a medical specialty society representing over 30,000 psychiatrists nationwide, would like to share with you our views regarding reauthorization of the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse and ask that the statement be made part of the hearing record on February 20th.

In our view, the authorizing authorities Section 513, Public Health Service Act (42 USC 29066-2); and Section 517, Public Health Service Act (42 USC 290cc-1), are anachronistic since their significance is no longer consistent with the overall agency structure and mission.

The problem arises because specific authorities have been enacted by the Congress for these two institutes. Appropriations committees, in making appropriations look first to specific authorities, then, if at all, to general authorities. Thus, while Section 301 is always cited as a general authority in Administration budget requests for these institutes, the specific authorizations enacted for these two institutes have been the ones utilized by the appropriations committees.

Thus, the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse are each in the anomalous position of not utilizing Section 301 of the Public Health Service Act, which does not require periodic reauthorization. These two institutes now perform research which is as good as any conducted anywhere in the world, with paylines and priority scores which are exceptional. These institutes have matured and should not be required periodically to come before the Congress to justify their existence as research entities. While this might have been appropriate when the Congress first established each of these institutes, it is clearly not now necessary with respect to both of these excellent research programs. We support the official Administration policy that all health research be conducted utilizing the general authority of Section 301. This lends stability to the research enterprise and allows flexibility to pursue new avenues of research (such as AIDS) without needing to seek a specific new legislative authorization.

This would not and should not, in our view, diminish the ability of the authorizing committees to set priorities or to establish set asides -- it would only allow the appropriations committees to determine annual research funding levels without the imposition of authorizing arbitrary budget constraint limitations.

We appreciate your attention to this matter.

Sincerely,

Jay B. Cutler
Special Counsel and Director
Division of Government Relations

JBC:PG:bj

Senator **Hawkins**. The hearing is adjourned.

[Whereupon, at 12 p.m., the subcommittee was adjourned.].

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